STOCKHOLM EVALUATION UNIT

MEDECINS SANS FRONTIERES LÄKARE UTAN GRÄNSER

A THEMATIC EVALUATION OF

INTEGRATED COMMUNITY CASE MANAGEMENT ACTIVITIES

IN MÉDECINS SANS FRONTIÈRES (MSF) - OPERATIONAL CENTRE BRUSSELS (OCB) SETTINGS

July 2025

This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

It was prepared independently by Eau Claire Consulting - Mary Kante, Malia Skjefte, and Laure Moukam.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

Admin	Administrative
ARO	Annual Review of Operations
ARI	Acute Respiratory Infections
ASACO	*Association de Santé Communautaire* (Community Health Association)
ASC	*Agent de Santé Communautaire* (Community Health Worker)
BHI	Boma Health Initiative
BHWs	Boma Health Workers
BPHNS	Basic Package of Health and Nutrition Services
CAC	*Comité d'Appui Communautaire* (Community Action Committee)
CCM	Community Case Management
CG	Consultation Group
CHA	Community Health Agent
CHE	Community Health Educator
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
CSCOM	*Centre de Santé Communautaire* (Community Health Facility)
CORP	Community Resource Person
DHIS2	District Health Information Software 2
DHMT	District Health Management Team
DMC	Decentralized Models of Care
DRC	Democratic Republic of the Congo
EH	Environmental Health
EPI	Expanded Programme on Immunisation
EQ	Evaluation Question

ER	Evaluation Report
FGD	Focus Group Discussion
FHCI	Free Health Care Initiative
GBV	Gender Based Violence
HEWs	Health Extension Workers
HIS	Health Information System
HP	Health Promotion
HR	Human Resources
HQ	Headquarters
iCCM	Integrated Community Case Management
IDI	In-Depth Interview
IDPs	Internally Displaced Persons
IMCI	Integrated Management of Childhood Illness
IMS	International Mobile Staff
IPC	Infection Prevention and Control
ITN	Insecticide-treated Nets
KGH	Kenema Government Hospital
KII	Key Informant Interview
LGA	Local Government Areas
LHS	Locally Hired Staff
LMIS	Logistics Management and Information System
M&E	Monitoring and Evaluation
MOH	Ministries of Health
MoHS	Ministry of Health and Sanitation
MOU	Memoranda of Understanding
MSF	Médecins Sans Frontières

MSF-OCB	Médecins Sans Frontières-Operational Centre Brussels
AC	Mid-Upper Arm Circumference
NAM	Nursing Activity Manager
NGO	Non-governmental organisation
OCBA	Operational Centre Barcelona and Athens
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PHU	Primary Health Unit
PMR	Project Medical Referent
RCMD	Routinely Collected Medical Data
RDT	Rapid Diagnostic Test
RE-AIM	Reach, Effectiveness, Adoption, Implementation, and Maintenance
ReCos	*Relais Communautaires* (Community Relays)
RNA	Routine Nutrition Assessment
RST	Regional Support Team
UNICEF	United Nations Children's Fund
SAM	Severe Acute Malnutrition
SCM	Supply Chain Management
SEC	*Soins Essentiels dans la Communauté* (Essential Care in the Community)
SEU	Stockholm Evaluation Unit
SV	Sexual Violence
SSC	*Site de Soins Communautaire* (Community Health Site)
TBA	Traditional Birth Attendant
TOR	Terms of Reference
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

This thematic evaluation explores the implementation, performance, and strategic recommendations for scalability and sustainability of **integrated Community Case Management (iCCM) activities** in the Médecins Sans Frontières-Operational Centre Brussels (MSF-OCB) portfolio as per end of 2024. In line with the Term of Reference, this evaluation is intended for use by MSF teams in OCB to reinforce ongoing priorities for accountability, continuous improvements, and organisational learning. Likewise, results of the evaluation should inform better understanding of operational realities of MSF and Ministry of Health (MOH) staff, community health workers (CHWs), and other partners to inform future planning for and implementation of iCCM programmes.

iCCM is an evidence-based community-based health strategy that enables trained CHWs to diagnose and treat the leading causes of under-five mortality and morbidity particularly in underserved and hard-to-reach populations, especially in remote or other settings where access to facility-based services is limited. These include uncomplicated cases of **malaria, diarrhoea, and pneumonia**, and referral for severe cases.[1] In many contexts where MSF operates, CHWs also screen for malnutrition and necessary vaccines.

We gathered in-depth information across three data streams (document review, qualitative, and quantitative) for **eight MSF-OCB projects,** which include between 2 to 115 iCCM activity sites per project, where iCCM activities were implemented in 2024[2]: Masisi (Democratic Republic of the Congo), Niono and Tombouctou (Mali), Cibitoke (Burundi), Kenema (Sierra Leone), Yei and EGPAA (South Sudan), and Kebbi (Nigeria). These sites represent diverse geographic, political, and epidemiological contexts, ranging from conflict zones to remote pastoralist communities.

The evaluation was conducted by Eau Claire Consulting (ECC) and followed a **mixed-method design**, including a comprehensive document review of more than 2,700 documents, analysis of routinely collected medical data (RCMD), and over 100 in-depth stakeholder interviews across all project sites, including in-person visits to iCCM activities in Niono, Mali, and EGPAA, South Sudan. Key informants included CHWs, caregivers, community leaders, MSF staff, MOH representatives, and global health actors. Ethical considerations included written and verbal sharing of detailed informed consent for voluntary and confidential participation in key informant interviews (KIIs) or small focus group discussions (FGDs) for participants above 18 years of age for this study intended for MSF's internal use. To minimize bias, translation was provided as needed for non-French or -English speaking participants and questions were provided to participants in advance for preparation and identification of any questions they preferred not to answer.

To organise the analysis, the evaluation examined five core evaluation questions refined and updated during the Inception Phase from those presented in the original Terms of Reference (TOR) (**Annex 1**),

[1] Child Health Taskforce, Integrated Community Case Management (iCCM) website – https://www.childhealthtaskforce.org/hubs/iccm.

[2] It came to the knowledge of the SEU, during the course of the evaluation that Bangassou project, CAR, was apparently implementing iCCM activities. As not included from start of the evaluation process, it remained out of scope.

within the **RE-AIM Framework**[3] (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and in alignment with the **eight iCCM benchmarks (programmatic areas) identified in the WHO and United Nations Children's Fund (UNICEF) Joint Statement for iCCM.**[4] These programmatic areas include coordination and policy making, costing and financing, human resources, supply chain management, service delivery and referral, communication and social mobilization, supervision and performance quality improvement, and monitoring and evaluation (M&E) and health information systems (HIS).

Limitations of the evaluation include a lack of clear guidelines for MSF-OCB project teams and resultant gaps in knowledge management as well as collection, analysis, presentation, quality and use of RCMD for iCCM activities within MSF-OCB; logistical constraints for the on-site interviews; and staff turnover which in some cases limited institutional awareness of iCCM activities.

The five evaluation questions are listed below, with summary findings from the report.

EQ1: What are the components of each iCCM intervention within the MSF-OCB portfolio, how is iCCM operationalized within MSF-OCB projects, and how are key decisions made?

Across the MSF-OCB portfolio, the **core iCCM package** is consistently focused on the management of **malaria and diarrhoea in children under five**. Case management of acute respiratory infections (ARI) is not implemented as part of iCCM activities in two MSF-OCB projects due to concerns expressed by MSF staff and the MOH regarding CHW capabilities and administration of antibiotics at the community level. Operationalization varies significantly across sites based on contextual needs, population movement, security challenges, and national health system structures. For example, some sites (e.g., Kenema and Masisi) integrate maternal and newborn health services, while others (e.g., EGPAA) use mobile models to reach nomadic populations. Key decisions around CHW management, supervision modalities, and referral systems are shaped by logistical constraints, security, and availability of human and financial resources. The absence of standardized implementation guidance across projects leads to wide variation in how iCCM is delivered, monitored, and evaluated.

EQ2: What is the rationale for site selection, design of the iCCM package in response to contextual factors, budget and planning approaches used, as well as differentiated project design for iCCM interventions across MSF-OCB projects?

Selection of iCCM sites typically relies on a combination of disease burden, remoteness, access barriers, and population vulnerability. Project teams use data from disease surveillance systems, population movement tracking, and reported project specific health assessments to guide decisions. Community

[3] Holtrop, JS et al (2021). Understanding and applying the RE-AIM framework: Clarifications and resources. Journal of Clinical and Translational Services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8327549/

[4] WHO/UNICEF (2012). Joint Statement for iCCM: An equity-focused strategy to improve access to essential treatment services for children. who.int/publications/m/item/an-equity-focused-strategy-to-improve-access-to-essential-treatment-services-for-children. Note: The iCCM Programmatic Benchmarks are further described later in the report.

participation in planning is common, with CHWs often selected by local leaders and populations. However, formal engagement with MOH in early design phases is inconsistent across sites.

MSF's projects are often situated in response to the priorities of MSF's humanitarian mandate to serve vulnerable populations in complex operating environments with limited access to care. Projects are often initiated in response to conflict, displacement, or the collapse of local health systems. The design of iCCM packages for children under five reflects these priorities and context and likewise aligns with and supports national and sub-national primary health systems taking into consideration specific geographical, security, health, and other contextual factors. For example, in Niono, Masisi, and Tombouctou, iCCM fills critical service gaps in conflict-affected areas. In EGPAA, iCCM is delivered through mobile services to pastoralist communities when water availability requires them to move away from fixed primary health units (PHUs). Related services to reach remote populations over five years are also incorporated alongside iCCM in these project settings. In Tombouctou and Masisi, for example, MSF teams also incorporate additional services at community level, such as mental health, nutrition, and gender-based violence screening and referral.

Budgeting and planning approaches are often reactive, driven by operational feasibility, resource availability constraints, and evolving security and logistical considerations. While iCCM activities may be funded through the Annual Review of Operations (ARO) process, the evaluation noted varying criteria used to make the decisions and ad hoc approaches to documenting decisions to fund, scale, sustain, expand, or cancel iCCM projects. Combined with the nature of MSF funding, which in some cases is time-limited to address arising emergency situations, this significantly reduces options for long-term financial planning. Furthermore, guidelines and tools for managing continuity of care after MSF funding ends, were not available. Interviews in one project site noted frustration from MOH and community members following the announcement of the termination of MSF iCCM activities. Feedback provided was that the decision was made in a unilateral fashion and without solutions for community health care seeking options. Guidelines and tools could include, for example, a checklist, case study, and/or best practice brief to reinforce MOH leadership of iCCM activities, ensure alignment with national policies, and support planning for domestic resource mobilization after MSF funding ends. The lack of consistent funding for CHW incentives, supervision, and supply chain support threatens scalability of iCCM activities.

Alongside these challenges, the **adaptability of iCCM interventions in MSF settings is a strength**. MSF teams demonstrate creativity in tailoring services to shifting needs, using real-time data and local insights to navigate dynamic contexts. However, a lack of an MSF-OCB-specific iCCM strategic plan, documented MSF expectations for operationalizing technical quality norms, as well as operational standards of practice (SOPs) across iCCM benchmarks limits opportunities to scale up iCCM activities and extend a harmonized set of additional services critical to community health in the contexts in which MSF operates. Operational SOPs could be developed, for example, in the form of a step-by-step guide or toolkit for standard design and implementation considerations for each programmatic benchmark.

EQ3: What are the successes, challenges, and lessons learned for iCCM interventions in the MSF-OCB portfolio for improving access to prompt, quality, person-centred care delivered closer to patients?

Through iCCM, MSF has strengthened **delivery of care to populations** otherwise excluded from the health system. In Masisi and Niono, for instance, CHWs are often the only accessible source of healthcare. Community ownership and involvement have increased trust and use, particularly where CHWs are locally selected and trained.

Integration with other services—such as nutrition, vaccination, and maternal care—has improved quality and expanded the package of services available and reach of iCCM. Investments in training, supervision, and community engagement have bolstered service quality.

Challenges persist in ensuring consistent commodity supply, supervision coverage, and CHW motivation. Geographic and security barriers were also noted by stakeholders as limitations to referrals and in-person supervision. Additionally, CHW incentives are often insufficient or irregular, undermining retention. Community behaviour, such as reliance on traditional medicine and referral refusal, further complicates access and continuity of care.

Key lessons include the **value of flexibility in service delivery**, the critical role of non-financial CHW incentives (training, recognition), and the importance of community participation in promoting trust and uptake. Mobile models and peer-to-peer supervision were also identified as effective strategies in insecure or remote settings.

EQ4: What are the strategic recommendations for iCCM interventions in the MSF-OCB portfolio for enhancing their effectiveness and reach?

Strategic priorities for enhancing iCCM effectiveness and reach are presented in **Section 8** of the report, following analysis of the results from the three data streams.

1. **Determine the level of prioritization which MSF-OCB places on iCCM activities within the continuum of care provided by project teams.** As iCCM is determined to be a priority approach, MSF-OCB can build on its current updates to its Medical Strategy to incorporate clear objectives for iCCM's role within the strategy.
2. **Identify resources needed and if resources (budget, dedicated staff time) are available and proceed with developing a formal MSF-OCB iCCM strategic framework and Toolkit** with user-friendly adaptable operational and technical tools to support harmonized scale up of iCCM activities on a foundation of the eight benchmarks in each site. The evaluation team estimates that a dedicated iCCM technical resource person would be needed. Toolkit development could be prioritised by benchmark and or health interventions and produced in phases, according to the available budget and resources.
3. **Pilot and Scale Adaptable Tools and Innovations** across the eight benchmarks.

4. **Continue Government Engagement and Transition Planning:** Continue to reinforce MOH involvement in new iCCM sites, with shared supervision, training, and commodity planning from day one.
5. **Improve Data Feedback and Community Ownership:** Roll out user-friendly data tools and participatory planning forums that empower CHWs and communities to drive service improvement.

EQ5: How should iCCM interventions across MSF-OCB projects in the portfolio align with national health strategies and opportunities to inform the future extension and scale-up of iCCM interventions and reinforce their sustainability?

The **scalability and sustainability** of iCCM interventions - focused on ensuring efficient implementation at scale as well as the long-term viability of iCCM service delivery, even after MSF resources are no longer available - depends on deeper alignment with national health strategies, improved government buy-in, and co-financing. While some projects (e.g., Yei) have successfully integrated with MOH structures and aligned with national frameworks like the Boma Health Initiative (BHI), others operate in parallel to national systems.

Formal recognition of CHWs by MOH remains limited in many contexts. Policy advocacy is needed to support the inclusion of CHWs in health workforce planning and budgeting. Overall, MSF can play a catalytic role in piloting innovative approaches, demonstrating impact, and facilitating handover to local actors.

Recommendations include:

- Engaging MOH early in project design and planning.
- Harmonizing tools and indicators with national systems (e.g., DHIS2 integration).
- Supporting MOH-led supervision and training models.
- Documenting and disseminating lessons learned to inform scale-up.

NEXT STEPS

In advance of the 2026 ARO process, the evaluation team recommends that MSF-OCB undertake a light-touch strategic planning process and develop a draft MSF-OCB Strategy which identifies standard iCCM care packages, additional elements which may be considered (or not), and links to a standard iCCM Toolkit. Strategy development can build on this iCCM Thematic Evaluation which provides an up-to-date landscape of challenges, opportunities, and recommendations which can directly inform development of the MSF-OCB strategy. The evaluation team also recommends that MSF-OCB:

- Determine the level of prioritization it places on iCCM activities within the continuum of care provided by project teams. As iCCM is determined to be a priority approach, MSF-OCB can build on its current updates to its Medical Strategy to incorporate clear objectives for iCCM's role within the strategy.

- Assess the level of resources required, and as budget and dedicated staff time become available, develop a formal MSF-OCB iCCM strategic framework outlining standardized care packages, technical quality norms, and operational standards.
- Review the MSF-OCBA Decentralized Models of Care (DMC) strategic plan and its 14 community-adapted care packages and use this as a foundation to develop step-by-step standardized iCCM design, technical and operational guidance, and tools—consolidated into an online iCCM technical platform or toolkit, modelled after the OCBA DMC online toolkit.
- Establish an internal iCCM strategy and knowledge management platform would support learning, scalability, and sustainability across the portfolio.
- Strengthen and formalize the needs assessment process used to plan iCCM activities. This includes developing a standard assessment tool or questionnaire that outlines essential data points and guidance for participatory consultation.
- Develop and disseminate standardized implementation guidance to reduce variation in how iCCM is delivered, monitored, and evaluated across projects.
- Develop a harmonized yet flexible iCCM training manual and tools which can be used across project sites and iCCM activities including manuals, and participatory learning exercises to support a standard yet adaptable approach to training that can scale while maintaining quality.
- Develop an iCCM training manual and tools fit-for-purpose for conflict-affected and/or low-literacy contexts.
- Identify additional non-financial incentives for CHWs—such as training and recognition—and strengthen community participation strategies to build trust and increase service uptake.
- Incorporate mobile models and peer-to-peer supervision were also identified as effective strategies in insecure or remote settings.
- Develop reliable transport or defined contingency protocols to reinforce clearer pharmaceutical and supply planning and shared accountability between MSF, MOH actors, and health facility personnel.
- Support supervisors to conduct monthly drug and patient register reconciliations.
- Develop plans for maintaining iCCM supplies after MSF support has ended. This may include drafting a supply transition roadmap during initial planning stages, detailing how procurement, storage, and reporting will be handed over to MOH or other actors over time.
- Pre-position commodities, engage local transportation networks, and ensure buffer stocks for CHWs operating in remote zones.
- Develop CHW self-assessment tools and simplified supervision grids to reinforce accountability in low-access zones, building community-based supervision, CHW capacity building and stronger collaboration with local health structures into iCCM activity designs.

- Support feedback loops to share health data with CHWs and communities that are accessible or actionable for frontline workers or the public.
- Strengthen supervisor capacity through targeted training and reduced caseloads to enable more effective clinical mentoring and qualitative feedback, beyond activity volume monitoring.
- Strengthening partnerships with national and global stakeholders will be critical to leveraging learning and identifying optimal approaches for scaling and sustaining MSF's contribution to community health delivery in fragile settings.
- Learn from and build on the experiences and expertise of MSF-OCB teams implementing iCCM activities. For example:
    - In Niono, a planned community management board was developed to reinforce community ownership and accountability for service delivery.
    - In Yei and Kenema, the use of structured supervision plans combined bi-monthly individual visits with monthly group sessions for reinforcing clinical skills and improving the quality of data collection.
    - In EGPAA, the transition to the BHI model disrupted existing M&E routines, requiring the adaptation of registers and indicators mid-implementation.

INTRODUCTION

BACKGROUND AND PURPOSE OF EVALUATION

A key informant from the evaluation summarized the Médecins Sans Frontières-Operational Centre Brussels (MSF-OCB) health strategy guiding integrated community case management development as follows, "*MSF-OCB aims to deliver prompt, quality healthcare near to households and patients, to reduce severe illness and delayed care seeking. To do so, MSF-OCB optimizes integrated person-centred health services and interventions across the continuum of care to address priority health concerns.*" As adopted by the World Health Organization (WHO) since 2016, integrated people-centred care envisions "*a future in which all people have equal access to quality health services that are co-produced in a way that meets their life course needs and respects their preferences and are coordinated across the continuum of care*."[5]

Integrated Community Case Management (iCCM) is a strategy developed to extend life-saving interventions, as an extension of the national health system, in remote and inaccessible areas. iCCM trains, supports, and supplies community health workers (CHWs) to provide diagnosis, treatment, and referral for three common illnesses of children under five: malaria, pneumonia, and diarrhoea.[6] iCCM may, in some settings, be accompanied by the provision of other community health interventions, such as nutritional assessment; referral for vaccinations; promotion of healthy behaviours; community-led monitoring; and surveillance.

Through iCCM, MSF-OCB has extended prompt, quality, people-centred healthcare in several settings to bridge gaps in access for several years. Document review provided partial information on the genesis of iCCM activities within MSF-OCB projects. Meeting reports mentioned a programme in Pibor, South Sudan, with a slide deck marked as "*not presented*" and showing planning elements for community case management of malaria, SAM, and diarrhoea, dated 2015. It is not clear if this programme was implemented. An economic evaluation of MSF projects in Khouroussa, Guinea, mentions community case management for malaria for children under five with a graphic showing a starting point in 2018. An evaluation of the community case management of malaria and diarrhoea in Bili, Democratic Republic of the Congo (DRC) provides more detail on that programme which began in July 2017 and ended in November 2019.

This evaluation will reinforce understanding of current iCCM interventions in different locations within the MSF-OCB portfolio and identify successes, challenges, and strategic recommendations to enhance iCCM activities in existing and future MSF-OCB health interventions.

This **thematic evaluation** focused on general patterns and trends, providing an overview across MSF-OCB iCCM interventions to inform MSF-OCB development and management of current and potential future

[5] WHO, Framework on Integrated People-Centred Health Services. https://www.who.int/health-topics/integrated-people-centered-care#tab=tab_2

[6] Child Health Taskforce, Integrated Community Case Management (iCCM) website:
https://www.childhealthtaskforce.org/hubs/iccm

iCCM activities to address priority health concerns. While the evaluation report (ER) includes a description of the MSF-OCB iCCM portfolio, including how iCCM is operationalized within the projects (e.g., types of sites, the packages of care provided, and the modalities of human resources management and supervision), this evaluation is not intended to produce comprehensive individual evaluations for each project.

To highlight successes, challenges, lessons learned, and future directions, case studies were developed to highlight caregiver, CHW, and staff experiences and perspectives. This incorporation of case studies reinforced understanding of the day-to-day realities of implementing iCCM interventions in the MSF-OCB portfolio.

Leveraging its external perspective and previous experience with iCCM activities in collaboration with Ministries of Health (MOH) and other partners, Eau Claire Consulting (ECC) provided impartial insights and identified opportunities, challenges, and recommendations in collaboration with MSF-OCB teams. To do this, ECC used document review, analysis of medical data, and inputs from key informants through remote and in-person interviews across the eight current MSF-OCB iCCM projects to respond to **five priority evaluation questions (EQ**):

- **EQ1:** What are the components of each iCCM intervention within the MSF-OCB portfolio, how is iCCM operationalized within MSF-OCB projects, and how are key decisions made? Decisions may include site selection, the modalities of human resources management and supervision, and the packages of care to be provided, including the standard iCCM package as outlined above and/or additional community health interventions and interventions for populations above five years of age, in response to identified needs. This EQ will consider analyses of (a) the data and information used in deciding to include iCCM activities in the MSF project (or not); (b) approaches to involve communities in project design and decision-making and extent to which communities were involved; (c) key project, health, and community stakeholders consulted; and (d) information collected to inform key decisions.
- **EQ2:** What is the rationale for site selection, design of the iCCM package in response to contextual factors, budget and planning approaches used, as well as differentiated project design for iCCM interventions across MSF-OCB projects in the portfolio?
- **EQ3:** What are the successes, challenges, and lessons learned for iCCM interventions in the MSF-OCB portfolio for improving access to prompt, quality, person-centred care delivered closer to patients?
- **EQ4:** What are the strategic recommendations for iCCM interventions in the MSF-OCB portfolio for enhancing their effectiveness and reach?
- **EQ5:** How should iCCM interventions across MSF-OCB projects in the portfolio align with national health strategies and opportunities to inform the future extension and scale-up of iCCM interventions and reinforce their sustainability?

These EQ align with the four EQ included in the original Terms of Reference (TOR) presented in **Annex 1**, with some modifications in line with inputs from the evaluation team, the Consultation Group (CG) members for the evaluation and the Stockholm Evaluation Unit (SEU) during the Inception Phase. This includes reformulating the original EQ statements in the form of questions, focusing on iCCM package

design in response to contextual factors rather than a deviation from a "*standard package*," and including successes, challenges, and lessons learned. Following discussions with CG members, EQ5 was added to examine the alignment of MSF's iCCM activities with national health strategies to enhance scalability and sustainability of iCCM activities.

EVALUATION FRAMEWORK

Our evaluation adopts a multi-dimensional approach structured around the RE-AIM framework, with a focus on eight key programmatic areas defined by the WHO and UNICEF iCCM benchmarks. This approach is designed to yield credible and actionable results, systematically assessing the performance of MSF-OCB's iCCM activities.

TABLE 1: ICCM THEMATIC EVALUATION MULTI-DIMENSIONAL APPROACH

WHO-UNICEF Benchmark	Relevant Evaluation Questions	RE-AIM Dimensions
1. Coordination and Policy Making	• EQ1 (how iCCM is operationalized and how decisions are made) • EQ5 (alignment with national strategies, scalability, and sustainability)	• Effectiveness • Adoption • Implementation • Maintenance
2. Costing and Financing	• EQ2 (planning and budgeting approaches used) • EQ5 (sustainability and scale-up opportunities)	• Effectiveness • Implementation • Maintenance
3. Human Resources	• EQ1 (modalities of human resources management) • EQ3 (challenges and lessons learned)	• Reach • Effectiveness • Implementation • Maintenance
4. Supply Chain Management	• EQ1 (how iCCM is operationalized) • EQ3 (challenges in maintaining services) • EQ5 (sustainability and scale-up opportunities)	• Reach • Effectiveness • Implementation • Maintenance
5. Service Delivery and Referral	• EQ1 (components and decisions on service delivery) • EQ3 (access, quality, and challenges) • EQ4 (recommendations for effectiveness and reach)	• Reach • Effectiveness • Adoption • Implementation • Maintenance

6. Communication and Social Mobilization	• EQ1 (community involvement in project design) • EQ3 (lessons learned) • EQ5 (community ownership, scalability, and sustainability)	• Reach • Effectiveness • Adoption • Implementation • Maintenance
7. Supervision and Performance QA	• EQ1 (supervision approaches used) • EQ3 (successes and challenges in quality assurance) • EQ5 (scalability and sustainability)	• Effectiveness • Maintenance
8. Monitoring & Evaluation and HIS	• EQ1 (data used for decision-making) • EQ3 (monitoring outcomes and challenges) • EQ5 (future alignment with national HIS)	• Reach • Effectiveness • Implementation • Maintenance

RE-AIM FRAMEWORK OVERVIEW

The RE-AIM framework is a widely used tool for evaluating public health interventions, providing a comprehensive assessment across multiple dimensions.[7,8] This framework allowed us to systematically examine the collective development, management, potential extension, sustainability of progress and scalability of iCCM activities, as presented in **Annex 2.**

The five dimensions of the RE-AIM framework are summarized as:

- **Reach:** The extent to which the target population is engaged by the project activities.
- **Effectiveness:** The impact of the project activities on key outcomes, including both benefits and potential adverse effects.
- **Adoption:** The degree to which relevant settings and staff are willing to initiate the project activities and why.
- **Implementation:** The fidelity with which the project activities are delivered and scaled as intended, including any adaptations made during delivery.
- **Maintenance:** The sustainability of the project activity effects and its continued use over time.

[7] Holtrop, JS et al (2021). Understanding and applying the RE-AIM framework: Clarifications and resources. Journal of Clinical and Translational Services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8327549/

[8] Shaw, R et al (2019).

While the WHO/UNICEF iCCM benchmarks (next section) guided our evaluation, not every programmatic area was assessed across all five dimensions of the RE-AIM framework; only the dimensions most relevant to each area were evaluated against it.

PROGRAMMATIC AREAS (WHO/UNICEF ICCM BENCHMARKS)

The WHO and iCCM benchmarks provide standards for eight programmatic areas essential for implementing community-based health interventions to improve child survival and health outcomes.[9] These benchmarks, presented in the WHO/UNICEF Joint Statement on iCCM, provide the operational framework to reinforce iCCM activities planning, implementation, and monitoring and serve as the primary focus areas for evaluating the programmatic components of iCCM.

The programmatic areas (benchmarks), as defined in the WHO and UNICEF Joint Statement for iCCM, are as follows:

- **Coordination and policy making:** Needs assessment and situation analysis for community-based treatment services, including geographical mapping of communities suitable for iCCM, national policies and guidelines in place to allow treatment at the community level, mapping of current community case management (CCM) activities and partners, and a national coordination mechanism for iCCM.
- **Costing and financing:** Costing exercise to ensure that necessary financing is secured.
- **Human resources:** Clear and well-articulated roles and expectations for CHWs and communities; comprehensive basic and refresher training plan for CHWs; and strategies for retention and motivation.
- **Supply chain management:** Appropriate 'child-friendly' medicines and supplies for iCCM included in the national essential medicines list; and procurement plan, inventory control, resupply logistics system and logistics management and information system (LMIS) for iCCM, coordinated by the pharma and supply teams with standard operating procedures.
- **Service delivery and referral:** Appropriate guidelines for clinical assessment, diagnosis, management and referral, including plans for rational use of medicines (and rapid diagnostic tests (RDTs) where applicable); referral systems (which provide a structured mechanism through which CHWs direct children showing danger signs or complications beyond their own capabilities to formal health facilities for timely and appropriate care) and counter-referral systems for iCCM (which provides the CHW with feedback after the child has received care at the health facility).
- **Communication and social mobilization:** Communication and social mobilization plan and strategy; and materials and messages for iCCM.

[9] WHO/UNICEF (2012). Joint Statement for iCCM: An equity-focused strategy to improve access to essential treatment services for children. who.int/publications/m/item/an-equity-focused-strategy-to-improve-access-to-essential-treatment-services-for-children

- **Supervision and performance quality improvement:** Plan and appropriate tools to support effective supervision, trained supervisors, and resources (e.g., vehicles, fuel) to conduct supervision and provide skills coaching to CHWs.
- **Monitoring and evaluation and health information systems:** Comprehensive monitoring framework and system for all CCM components, integrated within the national health sector plan and health information system; and operational research agenda for iCCM.

PROJECT DESCRIPTIONS

As presented in further detail in **Annex 3**, Full Project Site Descriptions, iCCM interventions across MSF-OCB project sites share a common vision: to combat child morbidity and mortality, particularly in regions where access to healthcare is limited by geographical barriers, conflict, or resource constraints, by bringing essential healthcare services closer to vulnerable populations. While this overarching vision is consistent across contexts, iCCM is just one component within broader MSF project portfolios that may include additional health services or priorities. Implementation of iCCM also varies by site, reflecting contextual adaptations and operational differences. These variations are a key focus of this evaluation and are mapped out in **Table 2** and further explored throughout the report.

Definition

iCCM is a community-based health strategy that enables trained CHWs to diagnose and treat the leading causes of under-five mortality and morbidity particularly in underserved and hard-to-reach populations, especially in humanitarian, remote, or conflict-affected settings where access to facility-based services is limited. These include uncomplicated cases of malaria, diarrhoea, and pneumonia, and referral for severe cases.

MSF-OCB iCCM activities are designed for **children under five** and respond to the three leading life-threatening illnesses for this age group: pneumonia, diarrhoea, and malaria, exacerbated by underlying malnutrition. To take advantage of community access and effectiveness, iCCM activities in MSF-OCB projects often extend their reach to other at-risk groups, over five years old, including pregnant and lactating women, internally displaced persons, and communities facing humanitarian crises.

MSF-OCB's core iCCM strategy involves delivering **a package of essential health services** at the community level. This typically includes the diagnosis and treatment of malaria and diarrhoea, and screening for malnutrition. Although pneumonia case management is part of the global standard core iCCM objectives and package, iCCM activities in Cibitoke and Masisi do not include diagnosis of cough/fast breathing, and treatment of acute respiratory illness (ARI) with antibiotics. MSF-OCB iCCM activities also include health promotion and education to encourage preventive practices, and the establishment of referral systems to connect community care with higher-level health facilities. In addition to this core

package, some interventions also incorporate malaria prevention measures like vaccination, nutritional support, and maternal and newborn care. Additional description is presented in **Table 2.**

TABLE 2: BRIEF DESCRIPTION OF AVAILABLE PROJECT ACTIVITIES AND ICCM SERVICES (AS PER 02/2025)

Project Site	Core iCCM Programme Components					Additional Elements		
	Malaria diagnosis and treatment	Pneumonia diagnosis and treatment	Diarrhoea diagnosis and treatment	Recognition and referral of danger signs**	Health promotion	Malnutrition screening and referral	Vaccination status assessment	Notes
Cibitoke (Burundi)	Y	N	N	N	Y	P*	Y	Malnutrition screening (P*=planned)
EGPAA (South Sudan)	Y	Y	Y	Y	Y	N	N	GBV services
Kebbi (Nigeria)	Y	Y	Y	Y	Y	Y	N	Environmental health improvement; free nutrition activities for priority populations
Kenema (Sierra Leone)	Y	Y	Y	Y	Y	Y	N	Referral linkages to Kenema Government Hospital
Masisi (DRC)	Y	N	Y	Y	Y	Y	Y	Referral for cases of SV and GBV; mental health services
Niono (Mali)	Y	Y	Y	Y	Y	Y	Y	Postpartum home visits; Mental health services
Tombouc-tou (Mali)	Y	Y	Y	Y	Y	Y	Y	Health post services for other diseases, mental health, nutrition screening, and GBV services

Yei (South Sudan)	Y	Y	Y	Y	Y	Y	Y	Screening and referral for severe acute malnutrition (SAM) and nutritional danger signs

*P= Planned

**Danger signs as described by Child Health Task Force[10]= 1) Convulsions, 2) Very sleepy or unconscious, 3) Chest in-drawing, 4) Vomiting everything, 5) Not able to drink or breastfeed

More detailed descriptions are provided in **Annex 3**.

[10] Malaria Consortium. (2013). Classification and Referral Algorithm: iCCM Uganda. https://www.childhealthtaskforce.org/sites/default/files/2019-06/Classification%20and%20Referral%20Algorithm_iCCM%20Uganda%28Malaria%20Consortium%2C%202013%29.pdf

METHODOLOGY

Evaluation design built on the inception phase of the evaluation, during which ECC also gathered information across the three data streams (1) document review, 2) qualitative data collected from key informant interviews (KIIs), and 3) quantitative data analysed from District Health Information Software 2 (DHIS2) and MSF project Excel files) in collaboration with the Evaluation Commissioner, CG, and Project Staff to refine the evaluation framework and ensure its relevance. These preparatory evaluation activities included (1) conducting 15 initial discussions during the inception phase, with six Consultation group members from MSF-OCB, eight Project Medical Referents from all eight projects with iCCM activities, and one Nursing Activity Manager (NAM) Outreach coordinator (**Annex 4**); (2) reviewing logical frameworks, reports, databases, the list of standard iCCM medical indicators (**Annex 5**), data collection and monitoring tools followed by preliminary discussions with MSF-OCB DHIS2 teams to improve our knowledge of the medical data collection system and identify gaps in data collection as noted in the Inception Report; and (3) reviewing more than 2,700 documents, identifying how global and project-level documentation addressed the eight inter-agency benchmarks for iCCM implementation and the RE-AIM evaluation framework, using a Document Review Guide to harmonize approach across the three evaluation team members. An excerpt of frequently consulted materials is included in **Annex 6**.

During the evaluation of iCCM activities, we analysed data from three data streams to develop well-informed, impartial, and independent recommendations for the project. The data streams included:

QUALITATIVE DATA

A core focus of the evaluation was to gather and analyse qualitative data derived from KIIs, focus group discussions (FGDs), observation of iCCM activities during two in-person project visits, and case studies. These data provided deep insights into contextual, operational, and human factors influencing iCCM implementation and outcomes. Narratives gathered from the interviews also allowed the evaluation team to highlight challenges, successes, lessons learned, and the nuanced dynamics between iCCM interventions in the MSF-OCB portfolio, the health system, and the communities they serve.

This section details the comprehensive approach used to gather and analyse the qualitative data for the evaluation of iCCM interventions in the MSF-OCB portfolio. By using a mix of KIIs and FGDs, we aimed to capture a diverse range of perspectives and generate insightful, evidence-based findings and recommendations.

KEY INFORMANT PROFILES AND RECRUITMENT

For the qualitative component of this evaluation, the team conducted KIIs with a diverse range of stakeholders to ensure a comprehensive understanding of iCCM activities across the MSF-OCB portfolio. Interviews included MSF project staff, coordination teams, regional support teams and cells, MSF-OCB headquarters (HQ) technical and medical staff, and external global iCCM stakeholders. During in-person

visits to selected project sites (Niono and EGPAA), the team also interviewed community members, parents and caregivers, CHWs, and MOH staff from health facilities to central levels.

The sampling approach prioritised balanced representation, considering gender, power dynamics, experience levels, and voices that are often underrepresented, such as community members, caregivers, and MOH staff from referral facilities. The final sample size included **115 participants** across key stakeholder groups. Community members, parents, and caregivers accounted for 32 participants at the community level, with additional participants included in FGDs during case study development. MSF project staff interviews covered 45 participants across various roles with representation from both locally hired staff (LHS) and international mobile staff (IMS), including Field Coordinators, Project Medical Referents (PMRs), Data and Pharmacy Managers, Health Promotion Officers, and iCCM Supervisors. MOH representatives, primarily engaged during in-person visits, included 15 participants from community, district, regional, and central levels.

The MSF Coordination Team was represented by 7 participants, including Heads of Mission, Medical Coordinators, and Finance and Human Resources (HR) staff. Cell and Regional Support Teams accounted for 3 participants, while MSF-OCB technical staff, including medical department advisors, totaled 11 participants. Finally, global stakeholders from an iCCM implementing partner provided insights on broader iCCM implementation. The full sample size breakdown is available in **Annex 7**.

A purposive sampling approach ensured that participants with key inputs to contribute were included, facilitating a wide range of perspectives. Collaboration with local project teams and community leaders helped identify and invite key informants, ensuring that qualitative insights captured the contextual and operational factors influencing iCCM implementation and outcomes across the MSF-OCB portfolio.

During data collection, in some cases we reached fewer than the number of KII participants estimated during the inception phase sampling, for example, for MSF Coordination as well Regional Support Team (RST)/Cell due to limited availability and responsiveness of some team members. Conversely, we reached more than the number of KII participants estimated in several categories, including Community Members, Parents, Caregivers, MSF Project and MOH Staff, as well as MSF-OCB Technical Staff. This variation reflects both strong engagement at the project and community levels and logistical challenges in accessing certain coordination-level stakeholders.

QUALITATIVE DATA COLLECTION

The evaluation team used a combination of individual in-depth interviews (IDIs) and FGDs to gather diverse perspectives across iCCM interventions. Interviews were conducted by one-two team members in English, French, or the local language of the project site, with translation support provided by MSF staff when needed. To minimize bias, whenever possible, translators were selected from MSF staff who were not directly identifiable as MSF personnel. MSF project staff assisted in identifying key informants and coordinating interviews.

Online interviews were recorded and transcribed where feasible. In-person interviews were recorded using a tape recorder or phone, with detailed notes also taken in Excel. Prior to each interview, written and/or verbal informed consent was obtained, ensuring participants understood the purpose of the

evaluation and how their information would be used. All participants were at least 18 years old, and interview questions were shared in advance to allow for preparation. Interviews typically lasted 45 to 60 minutes, balancing time constraints with the need for in-depth discussion.

All collected data was securely stored to maintain confidentiality and data integrity. The interview guide is provided in **Annex 8**, while copies of the informed consent forms for IDIs and FGDs are available in **Annexes 9** and **10**.

CASE STUDIES

To complement the thematic evaluation, the team conducted a field visit to two project sites, collecting data through FGDs and IDIs. This enabled them to develop three in-depth case studies to explore key aspects of iCCM implementation across selected MSF-OCB interventions. These case studies provided valuable insights into project design, implementation, and outcomes, highlighting both successes and challenges. The findings contributed to the identification of key programmatic elements which may need to be strengthened and/or leveraged to support future iCCM activities across the MSF-OCB portfolio.

Project visits were carried out in Mali (Niono) and South Sudan (EGPAA), with case studies selected based on factors such as the type of intervention package offered, language considerations (French and English, population characteristics (e.g., nomadic or economically vulnerable groups), and security conditions. Selection of the case study sites was informed by discussions with project staff, CG members, and the RST/Cell during inception phase interviews and follow-up communications. The RST/Cell also provided input on travel feasibility, accessibility, and security considerations.

During these in-country visits, the evaluation team conducted KIIs and FGDs with stakeholders at multiple levels, from central coordination to community members, including community leaders, parents, caregivers and Community Health Workers.

QUALITATIVE DATA ANALYSIS

Data preparation

The qualitative data analysis process began with the translation and transcription of interview recordings to ensure accuracy and completeness. Transcriptions were stored and analysed in a password-protected platform.

Thematic Analysis

Rather than developing a predefined codebook, we analysed responses by identifying common themes and findings across all responses for each discussion guide question. Once responses were summarized for all interview guide questions within a specific WHO benchmark or programmatic area (such as human resources), we used the evaluation questions as a guide to draft key findings, themes, and recommendations.

Cross-site Synthesis and Analysis

Findings were synthesized across all project sites to identify common themes and experiences within each iCCM programmatic area. This approach ensured that the analysis captured both context-specific insights and broader patterns relevant to iCCM implementation across the MSF-OCB portfolio. Finally, findings across all benchmarks were analysed to develop a core set of recommendations for each of the WHO/ UNICEF programmatic benchmarks.

QUANTITATIVE DATA

While no primary quantitative data was directly collected during the evaluation process, a variety of quantitative data sources were analysed to answer the evaluation questions. These data sources included data on screening, diagnosis, treatment, referrals, and other services provided to children collected and stored using MSF's internal guidelines and system. Both aggregated and disaggregated data stored in DHIS2 were downloaded to Excel, processed, and checked before analysis was undertaken to measure the reach and effectiveness of the activities and areas for improvement. Additional sources of RCMD, for example from MSF project Excel files were explored during the inception phase and not included for final analysis.

As part of this evaluation, it was intended that quantitative data would be used to complement the assessment of certain dimensions of the RE-AIM conceptual evaluation framework, specifically reach, effectiveness, and adoption. The analysis aimed to demonstrate the extent to which the objectives and desired outcomes of the iCCM intervention were achieved, as well as the adoption of the intervention by the various target groups. This adoption could be seen through appropriation by the target populations, an increasing number of new consultations, and effective referrals to referenced health facilities.

However, a thorough review of the data available, revealed inconsistencies and gaps in the data collection (and reporting system of the iCCM intervention). These issues made it impossible to conduct a meaningful analysis. Consequently, some indicators from the MSF standard iCCM medical indicators list were selected to examine key measures of the intervention, with results presented in **Annex 11**.

The goal was to produce historical overall performance trends for these standard medical indicators, from the start of the intervention in 2021 up to 2024, across all eight iCCM project sites. To achieve this, historical data for these indicators were downloaded from DHIS2 after analysis via the Data Visualiser Module. Medical data were downloaded for the following project sites: Niono, Tombouctou, Kenema, EGPAA, Yei, Cibitoke, and Masisi. For the Kebbi project site, iCCM data were available in Excel files. Additionally, for older project sites such as Niono and Tombouctou, data for 2021 and 2022 were only available in Excel.

These data, categorized by country and year, were first segmented by quarter for each year in a worksheet, where a column for calculation formulas was created. Proportions were then calculated quarterly and annually across all eight sites. Finally, based on the computed proportions, historical trend graphs were generated for each of the indicators.

DOCUMENT REVIEW

Information and insights gathered from the document review process formed the initial foundation of our learnings, which helped answer various evaluation questions throughout the analysis and served as valuable data sources and references throughout the evaluation.

ETHICAL CONSIDERATIONS

The evaluation team incorporated several key ethical considerations into the evaluation design and implementation. These included the development and sharing of detailed written and verbal informed consent for voluntary and confidential participation in advance of and during KIIs or small focus group discussions. Key informant interviews and FGD were reserved for participants above 18 years of age and aimed for broad representation, including underrepresented groups such as women, nomadic, and rural populations. Building on trusted working relationships in place, MSF-OCB project staff provided translation as needed for non-French or -English speaking participants. The evaluation team provided the discussion guides with participant questions in advance of KIIs and FGDs to allow participants time for preparation and identification of any questions they preferred not to answer. The evaluation team coordinated with MSF-OCB project staff to ensure that interviews were conducted in a safe, secure, and private location and endeavoured to ask questions in a sensitive manner and confirmed with participants that there would be no consequences for skipping any questions or stopping the interview at any time. For this final evaluation report, the team has presented final quotes and results in a de-identified manner to ensure privacy across levels.

LIMITATIONS

Evaluating iCCM interventions in humanitarian settings presented several inherent limitations that may have influenced the scope, representativeness, and reliability of findings. These limitations stemmed from methodological constraints, data availability, and contextual complexity. While some challenges were anticipated, this section focuses on core limitations and their implications for the evaluation, as well as mitigation strategies applied by the evaluation team.

- **Restricted access and security constraints:** Logistical issues, insecurity, and political instability at some project sites limited the evaluation team's access to certain geographic areas and stakeholders. As a result, perspectives from some sites may be underrepresented in the data. To mitigate this, interviews were conducted remotely when feasible, and deep dives were conducted in accessible locations to gather detailed insights.
- **Lack of direct observation of service delivery:** The evaluation did not include a component for direct observation of CHW service delivery. This limited the ability to assess implementation fidelity and provider-client interactions firsthand. Instead, the team relied on qualitative

interviews with CHWs, caregivers, and supervisors, as well as document review, to explore service delivery dynamics.

- **Purposive sampling and site selection constraints:** A purposive sampling approach was used to ensure a diverse and relevant mix of stakeholder perspectives across project levels and geographies. While some individual perspectives may have been missed due to the large-scale nature of this evaluation, data saturation was reached for key themes through this strategy.
- **Gaps in documentation and knowledge management systems:** The absence of a unified, MSF-specific iCCM strategy aligned with global goals, as well as inconsistencies in document organization and accessibility across project sites, posed challenges to the completeness of the review. Difficulties included fragmented repositories, lack of standardized nomenclature, and limited availability of iCCM-specific documentation in some contexts. These gaps constrained the ability to systematically compare strategies and results across sites. In response, the team triangulated data sources and actively followed up with project teams to retrieve missing or clarifying documents.
- **Limitations in secondary data quality and availability:** Secondary data used to inform the evaluation varied in completeness and reliability. In some countries, inconsistent age disaggregation and misalignment between project data and national health information systems (e.g., DHIS2) complicated the analysis of routine community-based data (RCMD). Additionally, in some older sites project data were only available in DHIS2 from 2022 onward, limiting the evaluation's ability to assess longer-term trends or anomalies over time. With further analysis during the evaluation, data quality issues were noted to be increasingly prominent and concerning. Consequently, time series or outcome trend analysis was not feasible. To address this, findings from routine data were interpreted with caution and cross-checked with qualitative insights and documentation. Furthermore, core impact or effectiveness measures, such as population-level coverage or changes in service quality, were beyond the scope of this evaluation, as they would have required a more extensive study design, such as baseline and endline surveys or quasi-experimental methods.

To address these limitations, the evaluation team:

- Conducted deep dives at selected project sites to capture detailed insights.
- Prioritised key documents to ensure the most relevant information was reviewed and active retrieval of missing documents through engagement with field teams.
- Triangulated data from multiple sources and used robust analytical techniques to enhance data validity.
- Provided significant time availability beyond that which was planned.

KEY RESULTS AND RECOMMENDATIONS

BENCHMARK 1: COORDINATION AND POLICY MAKING

This benchmark assesses the extent to which a needs assessment and situational analysis for community-based treatment services was conducted to inform design of iCCM interventions. It also examines if national guidelines are in place to allow iCCM, and the extent to which iCCM interventions are aligned with these iCCM and/or health policies to enable effective implementation, scale, oversight, and sustainability. It includes the presence of enabling policies, mapping of iCCM services and partners, and coordination mechanisms across key stakeholders.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (how iCCM is operationalized and how decisions are made) • EQ5 (alignment with national strategies, scalability, and sustainability)	• Effectiveness • Adoption • Implementation • Maintenance

FINDINGS

Key informants across MSF-OCB projects highlighted coordination and policymaking as central to the effective implementation of iCCM, with marked variation in how interventions were aligned with national strategies and managed in collaboration with the MOH. In project sites such as South Sudan, DRC, Nigeria, and Sierra Leone, project teams successfully **embedded iCCM into government frameworks** (e.g., the BHI and national CHW programmes), allowing for standardized supervision, joint implementation, and aligned tools. In contrast, while the integration of iCCM in Mali aligned with the national *Soins Essentiels dans la Communauté* (SEC) strategy, contextual factors, including insecurity and limited access to formal health facilities, required adaptation of the MSF model to work through peripheral health posts and Association de Santé Communautaire (ASACOs, or "*Community Health Association*"), where consultations were typically performed by CHWs, with support or supervision from MSF nurses when feasible. The evaluation team interprets this variability as a reflection of both context-specific operational constraints and MSF's ability to adapt to local realities, as well as the absence of a formal MSF-OCB strategy or policy for iCCM, which may limit organisational coherence, cross-project learning, and the ability to replicate strong approaches where appropriate.

While many project teams reported conducting needs assessments, community consultations, or baseline surveys to guide iCCM design, the **documentation and standardization of needs assessments varied considerably.** Some assessments were conducted informally or were not stored or shared in ways that would allow for use by other sites. This limits the value of these assessments as a learning tool and creates missed opportunities for programmatic alignment across contexts. Projects that embedded participatory decision-making processes—such as programs aligned with South Sudan's BHI model, which feature

structured community involvement through village-level health committees—demonstrated stronger local ownership and accountability. Engagement of community members and leaders also strengthens iCCM. One respondent noted, *"We do community meetings to inform them about the MSF plan to support selected communities in the iCCM package. We discuss the support of the community... [with] representation from the chief in each community and the CHW of that community."* The evaluation team interprets this as evidence that **meaningful engagement of community leadership at the design stage enhances legitimacy and community investment in iCCM.**

In some contexts, the term "*iCCM*" was seen as unfamiliar or foreign, particularly in Francophone countries. A nurse remarked, "*Le terme iCCM est un mot anglais, ce qui posait déjà un problème. Nous devrions utiliser le terme Soins de Santé Communautaires..."* The evaluation team understands this as a signal of the importance of using locally accepted terms and framing when engaging MOH partners, to improve recognition, policy uptake, scalability, and sustainability.

Findings from the document review reinforced these interview insights. **Service packages, CHW compensation approaches, and referral protocols varied across sites**. Few projects had regular coordination meetings or formal agreements with MOH counterparts. In the absence of a shared MSF-OCB framework, teams made commendable adaptations to local conditions, but these were often isolated innovations rather than part of a broader institutional learning loop.

Despite these challenges, **MSF demonstrated strong capacity for local adaptation**. In highly variable settings—ranging from pastoralist communities in EGPAA to conflict-affected areas like Tombouctou—project teams adjusted service models to reflect population movement, access constraints, and community norms. These adaptations, while impressive, were not guided by a common strategic vision or reviewed systematically across MSF-OCB. This reinforces the need for a shared reference point to support strategic alignment and long-term planning.

Scalability and sustainability concerns were raised consistently across KIIs. While projects like Yei and Kenema had initiated steps toward transition—through MOH capacity-building and gradual handover of supervision and supply management—others lacked formal exit plans or defined approaches to scale service delivery. As one coordinator explained, "*Le plus grand défi est celui des ressources. Les besoins sont immenses et MSF n'est pas en mesure de déployer des services dans toutes les zones qui en ont besoin."* The evaluation team interprets this as a call for stronger upstream planning with the MOH and clearer internal guidance on effective approaches to scale iCCM and what constitutes a "*sustainable*" iCCM model in the MSF context.

Building Blocks for Scalability and Sustainability. Several MSF-OCB project sites have made meaningful progress in embedding iCCM into local health systems, laying the groundwork for scaling iCCM and long-term sustainability. In Yei, South Sudan, integration of iCCM into the government-led BHI has allowed for standardized tools, aligned supervision structures, and joint implementation with local health authorities. Similarly, in Kenema, Sierra Leone, the MOH has taken increasing ownership of CHW supervision and commodity management, with MSF stepping in only when gaps emerge. These examples highlight that when national frameworks, strong community engagement, and harmonized tools are in place, iCCM services are more likely to be replicable and endure beyond MSF support. MSF should continue fostering government co-leadership while strengthening community engagement, ensuring that CHWs are supported by both the system and the community at all levels of intervention implementation.

RECOMMENDATIONS

To improve coordination and policy alignment, MSF should first **strengthen and formalize the needs assessment process** used to plan iCCM activities. This includes developing a standard assessment tool or questionnaire that outlines essential data points (e.g., CHW coverage, community health priorities, facility access) and guidance for participatory consultation. The tool should include a section to document how information is collected, analysed, and used in project activity design, and findings should be stored in a central repository to support cross-site learning. This will ensure that planning is based on both quantitative and qualitative data and that future iCCM activities respond to documented needs.

Second, MSF should implement a clear process to document how each iCCM project aligns with or diverges from global definitions of iCCM and national health guidelines. In cases where MSF-supported interventions differ from national norms—such as expanded age eligibility, CHW incentive models, or referral protocols—MSF should develop short, documented justifications that are reviewed and agreed upon with MOH stakeholders. This will support transparency, facilitate alignment over time, and reduce confusion among frontline staff, partners, while also serving as a resource for internal learning.

Third, MSF should **develop a formal MSF-OCB iCCM scalability and sustainability approach**, drawing from this evaluation's findings. A simple strategy should articulate how to cost-effectively scale quality iCCM activities as well as what "*sustainability*" means for MSF iCCM projects, key actions and indicators, and guidance for transition planning. This draft should be validated through consultations with iCCM activity staff, project teams, MOH partners, CHWs, and community representatives. Their feedback should be incorporated into a final version, which can then be reported against using a simple monitoring template or checklist. The final framework should be referenced during start-up of activities, review, and exit planning.

Building on these foundational actions, **MSF-OCB should determine the level of prioritization it places on iCCM activities** within the continuum of care provided by project teams. As iCCM is determined to be a priority approach, MSF-OCB can build on its current updates to its Medical Strategy to incorporate clear

objectives for iCCM's role within the strategy. Then, the MSF-OCB team can determine the level of resources needed, and as resources (budget, dedicated staff time) are available, should proceed with developing a formal MSF-OCB iCCM strategic framework that outlines standardized care packages, technical quality norms, and operational standards. This strategy should incorporate key learnings from the current evaluation, including findings related to integration, supervision, and health system partnerships. A light-touch strategic planning process in advance of the 2025 (for 2026) Annual Review of Operations (ARO) cycle, for example, could serve as a springboard for this effort. The strategy should then inform the development of standard MSF-OCB iCCM technical and operational tools. Following the experience of MSF-OCBA, these tools could be compiled into a shared online toolkit accessible to all MSF-OCB, project, and iCCM staff—with selected components shared with MOHs and implementing partners.

At the country level, MSF should **support and reinforce dedicated MOH-led iCCM coordination**. This includes joint planning of activities, formalizing supervision systems, aligning CHW training with national standards, and integrating iCCM data into national health information systems (e.g., DHIS2). Institutionalizing MSF representation in national coordination platforms and policy forums will help ensure that project-level lessons inform broader health system strategy.

Community engagement mechanisms should also be standardized across iCCM sites. These should include structured feedback loops, participatory planning forums, and mechanisms for shared accountability. MSF can also explore harmonized CHW retention strategies—such as mentorship, psychosocial support, and local recognition systems—aligned with national workforce development plans. To strengthen MOH leadership and integration with the national health system, MSF could go beyond training and supervision by supporting MOH-led planning, coordination, and data systems, particularly in contexts where iCCM staff work part-time or on a voluntary basis.

Lastly, **language barriers should be addressed** using locally accepted terminology (e.g., Soins de Santé Communautaire) in Francophone contexts to facilitate national uptake. Strengthening government capacity through joint supervision and phased handover of tools and responsibilities will be critical to ensuring effective scaling up and long-term sustainability of iCCM services.

BENCHMARK 2: COSTING AND FINANCING

This benchmark examines the financial components of iCCM interventions, including project planning, costing, and budgeting processes and tools, MSF-OCB resourcing allocation, and iCCM activity transition planning. It also explores how MSF-OCB supported projects coordinate with MOHs and other health and community partners and plans resource needs for eventual scale-up to add new health interventions or new iCCM sites, or to facilitate the handover of iCCM activities when MSF-OCB projects close.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ2 (planning and budgeting approaches used) • EQ5 (sustainability and scale-up opportunities)	• Effectiveness • Implementation • Maintenance

FINDINGS

Costing and financing emerged as a central factor influencing the scale and scope of iCCM activities, medium- and long-term continuity, and integration of iCCM services into national health systems and financing structures across MSF-OCB project sites. Integration refers not only to aligning MSF-supported activities with national guidelines, but also to embedding iCCM costs—such as medicines, training, and CHW compensation—into MOH budgets, essential medicines lists, and national health financing mechanisms.

In EGPAA, for example, CHWs received salaries directly from the MOH, with MSF providing training and supervision, demonstrating partial integration of financing responsibilities. In Masisi, MSF-led iCCM services were implemented in parallel to the MOH system, but without clear financial coordination, raising concerns about sustainability after MSF's exit. Key informant interviews affirmed that **MSF's financial contributions have been instrumental in launching and sustaining high-quality iCCM interventions**—covering core expenses such as iCCM activity staffing, CHW incentives, training, supervision, supply chains, reporting, and medical commodities.

To effectively scale iCCM activities beyond the 2 to 115 iCCM activity sites per project will require tools which support more complete and standardized planning and costing. However, many project teams noted that iCCM planning and budgeting often assumes that existing resources for facility-based services will be available and sufficient to extend services to a few additional iCCM activity sites. While costs are typically integrated into broader project budget lines to enable efficient resource use, the evaluation team found a lack of dedicated or detailed planning tools specific to iCCM, such as per-site cost estimates, additional vehicle and personnel needs for training and supervision. This can make it difficult to systematically assess, track, or communicate the full investment required. Developing more structured costing tools within the existing budgeting frameworks could also help to better valorise iCCM activities and inform future planning. Furthermore, **financial transition planning to ensure continuity of iCCM activities after MSF's direct involvement ends was not observed or noted** during KIIs. Where MSF operates in a geographic area for emergency response purposes, naturally MSF may close those operations after the emergency has been resolved. The annual funding and ARO process also does not seem to encourage medium- and longer-term funding. In the absence of clear handover strategies or defined roles for MOH or non-governmental organisation (NGO) partners, **uncertainty about future funding responsibilities has raised concerns**. As one respondent stated, "*MSF really needs to think about this question: who will take over this project after we've gone?*" The evaluation team understands this as an opportunity for MSF to enhance its forward planning by embedding transition strategies into initial project design.

Many project and iCCM activity teams highlighted **challenges in ensuring appropriate and consistent compensation for CHWs** across projects, particularly in contexts where MSF aims to scale services. Delays or gaps in incentive payments were reported in several iCCM activities and in some cases MOH policy does not support payments to CHWs, which may affect CHW morale and retention. One interviewee noted, *"Sustainability is not MSF's strong point in general... it's difficult because CHWs are often volunteers. It is therefore complicated to ask more of them without offering them real incentives."* The evaluation team interprets these challenges as reinforcing the importance of developing structured, context-appropriate CHW motivation models that align with national CHW frameworks while acknowledging budget constraints and MOH requirements. In Mali, periodic delays in incentive payments led to friction with local health authorities and disrupted CHW motivation. In Cibitoke, some CHWs worked without compensation, depending on MSF-provided materials and community recognition alone. Insights from the document review revealed **variability in how financial planning and budgeting are operationalized across sites**. While budget ceilings are established at HQ level, project managers often lack dedicated tools to forecast and plan for iCCM-specific costs such as training, supervision, or data collection. In addition, visibility into national health budget allocations for community health remains limited in many settings. The evaluation team views this as a key area for strengthening MSF's collaboration with MOH actors and exploring opportunities for cost-sharing or integration into national health plans.

Geographic and logistical realities also shaped financial needs, particularly in remote or insecure areas. Projects in locations like Yei and Tombouctou faced higher operational costs due to reliance on aerial delivery systems or mobile clinics. These adaptive strategies enabled continued service delivery despite contextual challenges and highlighted MSF's commitment to reaching underserved populations. However, the evaluation team believes these same conditions call for more robust financial feasibility assessments before scale-up or transition planning, to ensure alignment between operational models and available resources over the medium- and long-term. In contrast, project teams in Kebbi and Masisi operated with more predictable transport and supply mechanisms, reducing costs and offering models for lower-intensity financial planning in more stable contexts.

Although a cost-effectiveness analysis was not conducted as part of this evaluation, limitations were flagged by the evaluation team with regards to the possibility to use quantitative data for robust financial and programmatic analyses, for example due to issues with data completeness and the variability of monitoring systems across project sites. Incomplete tracking of referral outcomes, malnutrition indicators, and CHW caseloads across some sites also point to missed opportunities for financial and programmatic optimization. Strengthening routine data collection and harmonizing indicator definitions would not only improve project quality but also enable more informed financial planning over time.

Finally, the **importance of aligning iCCM financing with national frameworks** was consistently emphasized. One interviewee reflected, *"You have to read the national policies and assess what is possible... we also need to work more with health economists to assess the financial viability of scaling up."* The evaluation team sees this as a promising avenue for MSF to pursue co-financing with external donors where acceptable, leverage multilateral support, and develop integrated financing strategies that enhance long-term project ownership.

RECOMMENDATIONS

To ensure iCCM services are scalable and sustainable, MSF should **prioritise early operational and financial feasibility assessments** before any start-up or scale-up activities. These assessments would help tailor project design to local realities, including logistical costs, MOH involvement, and community structures, ensuring that services can be maintained within existing systems and budgets. For example, in Masisi, the predictable supply chain and existing health infrastructure allowed for weekly CHW resupply with lower transport costs—offering a model that contrasts with higher-cost, remote project activities like those in Tombouctou, although this level of regularity is not always feasible in other settings due to security constraints. Where appropriate, integrating iCCM costs into MOH budgets or national health insurance schemes—particularly for essential medicines, CHW stipends, and training—should be actively pursued.

To strengthen scalability and long-term financial sustainability of iCCM interventions, MSF and its partners should also **prioritize the development of comprehensive programmatic and financial transition plans** from the start of any iCCM activity. These plans should be co-developed with MOH counterparts, donors, and relevant NGOs to ensure shared responsibility and alignment with national financing structures. They should include standard procedures for both iCCM activity start-up and a multi-layered review process before iCCM activity termination. Incorporating these strategies early in project design is critical to avoid abrupt funding gaps during scale-down or handover phases.

Given the centrality of CHWs to the success of iCCM, MSF should **explore scalable, sustainable, and context-appropriate incentive models**. These could include a mix of financial incentives, in-kind support, career development opportunities, and formal recognition, aligned with national CHW frameworks to prevent the creation of parallel systems. In EGPAA, for instance, CHWs received both government salaries and MSF-provided training and supervision, illustrating a shared investment model. In Masisi, CHWs received modest cash stipends alongside livestock (e.g., goats or sheep), which served as culturally appropriate, longer-term incentives. Ensuring consistency across project sites will require a harmonized incentive framework co-developed with national actors, while maintaining flexibility to adapt to context.

BENCHMARK 3: HUMAN RESOURCES

This benchmark examines the selection, training, supervision, motivation, and retention of CHWs across iCCM project sites. It assesses the clarity and articulation of well-defined roles and expectations for CHWs, communities, MSF, MOH, and partners; the alignment of human resource practices with MOH systems; and the adaptability of capacity-building approaches to local contexts. It also evaluates the presence of comprehensive basic and refresher training plans, strategies for CHW retention and motivation, and the overall effectiveness of workforce systems in supporting the delivery of iCCM services—particularly in remote, mobile, and crisis-affected communities.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (modalities of human resources management) • EQ3 (challenges and lessons learned)	• Reach • Effectiveness • Implementation • Maintenance

FINDINGS

Human resources emerged as a pivotal driver of iCCM effectiveness across MSF-OCB projects, with trained, motivated, and appropriately equipped CHWs selected and supported by their communities consistently recognised as essential to extending access to prompt quality healthcare for children under five and their families in underserved areas. In nearly all project sites, findings from KIIs found that **CHWs were selected through community-led processes**—often by village chiefs or health committees—which contributed to strong community trust and a sense of local ownership. In contexts such as Yei, Masisi, Kebbi, and Kenema, where selection criteria aligned with MOH frameworks and incorporated standards for literacy, age, and residence, CHWs were effectively integrated into the national health system. In Yei, South Sudan, each BHW is expected to serve 40 households, though in some cases, a single CHW has been responsible for over 80 households, necessitating additional recruitment. In Masisi, EGPAA, and Niono, MSF worked jointly with local leaders to identify CHWs based on residence, availability, and literacy, though gaps in formalized criteria and population estimates led to uneven CHW coverage. In Cibitoke, under-coverage in remote zones and over-concentration near health centres resulted in geographic disparities. **In some cases, community leaders influence CHW distribution based on subjective factors** rather than objective needs, raising concerns about efficiency and fairness. In Kenema (Sierra Leone), CHWs are predominantly male, largely due to the higher secondary school completion rates among men. Key informants also shared that 15% of Community Oriented Resource Persons (CORPs) in Kebbi are female, which also presents a gender imbalance among CHWs. While educational attainment is often considered a prerequisite for CHWs due to their role in delivering health messages, this is not consistent across all projects. For example, in EGPAA, where literacy and formal education are rare, these criteria were not required. In contrast, in Kenema, education-based selection criteria limited the pool of eligible female candidates, highlighting an opportunity to reinforce gender equity in CHW recruitment. The evaluation team sees this as a lesson learned that could inform more systematic, data-driven planning for CHW distribution and support more inclusive selection practices where feasible.

Training and supervision were areas of both strength and ongoing development. Many projects have introduced adaptive strategies in collaboration with MOH—such as handwritten flip charts to **streamline the available WHO training manual which was noted to be too complex for practical use** or the use of MOH-certified trainers and national protocols. Sites like Yei and Kebbi incorporate job aids such as iCCM chart booklets and prescription cards to support CHWs, while Masisi and Boma have introduced flip charts to accommodate lower literacy levels. One CHW shared, *"We are using the national protocols and guidelines... all training is done in collaboration with the focal person of the CHW effort from the Ministry."*

These integrated approaches have contributed to alignment and legitimacy. In EGPAA, the MOH-led training process included multi-phase certification and was supplemented by MSF follow-up and refresher courses. In Tombouctou, however, recent scale-up left some CHWs with delayed or shortened training, and there were gaps in access to job aids. The evaluation team noted **a gap at MSF-OCB level of a harmonized yet flexible iCCM training toolkit** which can be used across project sites and iCCM activities including manuals, and participatory learning exercises to support a standard yet adaptable approach to training that can scale while maintaining quality. Overall, CHWs consistently expressed a desire for ongoing learning, supported by tools fit for purpose for conflict-affected and/or low-literacy contexts and support to strengthen their ability to serve their communities.

Across project sites, supervision structures vary in frequency and format, with some projects benefiting from daily oversight while others face logistical and security-related challenges that limit regular visits, as seen in contexts like Yei. In some insecure settings where project teams cannot safely reach iCCM sites, CHWs are instead asked to travel to the MSF base for supervision, drug refills, and training. However, **the absence of formalized tools such as supervision checklists and behaviour evaluation forms in some sites reduces the ability to systematically track CHW performance over time**.

From the document review, several **gaps in documentation of CHW roles, deployment strategies, and supervision processes** were noted. While some sites maintained comprehensive records, others lacked clarity on whether CHWs were formally recognised within MOH structures or whether MSF-led training and supervision were aligned with national standards. In particular, the division of supervisory responsibilities between MSF and MOH actors was often not clearly documented. Supervision was typically led by MSF project staff, such as nurses, activity managers, or health promotion supervisors, though coordination with MOH district focal points or community health supervisors varied across contexts. These inconsistencies in TOR limited cross-site learning and inhibited efforts to standardize tools and approaches. In EGPAA, CHWs received a monthly government stipend in addition to MSF support. In contrast, CHWs in Cibitoke and parts of Tombouctou worked on a voluntary basis, often without contracts or formal documentation of responsibilities. These differences affected both retention and sustainability planning, particularly in areas where MSF's long-term role was uncertain.

Importantly, **CHWs expressed pride in their role and described strong respect and social support from their communities** as a motivating factor. Material support—such as bags, boots, radios, or livestock—as well as monthly meetings and public recognition, were cited as key retention strategies. One respondent in Yei explained, *"They are highly valued in their community, which helps to motivate them… they know they will be integrated into the MOH system, and that motivates them."* At the same time, the **lack of consistent financial incentives or formal recognition** across project sites remained a pressing concern. In Masisi, CHWs received a modest cash allowance and, in some cases, livestock as an additional incentive. In Kebbi, logistical support—such as transport stipends, regular feedback sessions, and monthly team meetings—played a central role in maintaining engagement. The evaluation team believes that the absence of a standardized incentive framework contributes to disparities in retention and underscores the need for closer alignment with MOH employment policies.

While the quantitative data set was not used to analyse CHW performance directly, issues with incomplete data—such as inconsistent population denominators and variable reporting on training or supervision

activities—limited the ability to fully assess human resource coverage and needs. **Strengthening routine monitoring and aligning indicator definitions across sites would help improve planning** and ensure that CHW support strategies are data-informed and equitable.

The evaluation found that **despite these structural weaknesses, CHWs demonstrated remarkable resilience and adaptability.** Many balanced their health work with farming, childcare, or other responsibilities, underscoring the importance of flexible scheduling and recognition of CHWs' dual roles. In Tombouctou and Cibitoke, for example, CHWs spoke about walking long distances to reach households, often using their own resources to do so, which affects morale and sustainability. These insights emphasize the need for tailored support models that reflect the reality of frontline service delivery.

Finally, the evaluation team noted that MSF's human resource systems for iCCM often functioned in parallel with national systems rather than being embedded within them. In EGPAA and Niono, efforts to align training and supervision with MOH protocols were underway, but staff still expressed concern about how CHWs would be supported post-MSF. Without stronger alignment with national HR policies and investment in government transition plans, the long-term impact of CHW training and support risks being short-lived.

Expanding the Reach of iCCM Services Through Community-Driven Models.

MSF's iCCM interventions have aimed to extend life-saving care to remote and underserved communities through strong community-driven CHW models. In most project sites, CHWs are selected by local leaders, ensuring trust and social cohesion, while training and supervision models are tailored to varying levels of literacy and access. Across sites, population growth, migration, and limited census data hinder equitable CHW distribution, but MSF teams have introduced innovative solutions—such as flip charts for low-literacy settings and community-based census exercises in Masisi—to strengthen coverage. These context-specific tools and approaches could be centralized and shared more systematically across missions, forming the foundation of a practical iCCM field toolkit hosted on a shared platform, such as SharePoint. While gaps in refresher training and workforce allocation remain, the CHW model remains central to the reach and resilience of iCCM across diverse and fragile contexts.

RECOMMENDATIONS

To strengthen human resource systems for iCCM, a harmonized approach to CHW selection and deployment is needed within the same project—one that balances community preferences with health needs and population-based data. MSF should **invest in systematic population mapping to inform equitable workforce distribution** and avoid ad hoc or politicized placement. This could include periodic community-based micro-census exercises, as piloted in Masisi, to adjust CHW-to-household ratios in real time, while recognizing the limitations of this approach in settings with high population mobility due to insecurity, where accurate population estimates remain difficult to obtain.

Training packages and supervision protocols should also be standardized within each country and flexible enough to align with MOH priorities, with core modules, literacy-adapted materials, and refresher sessions institutionalized to ensure consistency in CHW capacity while acknowledging that criteria and requirements may vary between countries. Site-based mentoring and the use of visual job aids should be expanded, especially in low-literacy contexts. Supervision structures should also be reinforced, leveraging community-based models and ensuring frequent, supportive interactions between CHWs and supervisors. Where possible, CHW feedback can be built into supervision systems to foster two-way communication.

To support this, MSF should develop **a practical human resources toolkit for iCCM**, containing standard but flexible guidance documents—including adaptable templates, job descriptions, onboarding flows, supervision checklists, and TOR for CHW-MOH-MSF collaboration. The toolkit should reflect lessons from existing OCB resources and offer modular guidance that can be adapted to different operating environments, including conflict zones, low-literacy contexts, and areas with population flux.

CHW motivation and retention require immediate attention. MSF should work with MOH and partners to develop and advocate for standardized incentive packages—combining financial, material, and social recognition elements—aligned with national policies. Where possible, formal MOH employment of CHWs should be pursued, and interim support from MSF should be clearly linked to government transition plans. Examples from EGPAA, where CHWs received both MOH salaries and MSF incentives, can inform shared financing models. In Masisi, local livestock-based incentives were appreciated but lacked clear criteria—emphasizing the need for transparency in non-cash incentive schemes.

Additionally, MSF should **consider defining minimum supervision ratios and frequency benchmarks** for CHW project activities to ensure that even in remote or insecure areas, core performance oversight is maintained. In contexts where mobility is restricted, remote check-ins, peer coaching models, or village-based supervision committees should be explored.

Finally, **CHW performance tracking and feedback loops should be institutionalized**, enabling CHWs to contribute to service improvement through regular data reviews and peer learning forums. This would not only enhance accountability but also reinforce their sense of value and professional identity within the health system. In Tombouctou and Cibitoke, where CHWs reported limited supervision and unclear recognition structures, formalized peer review and data sharing could enhance both motivation and service quality.

CASE STUDY 1: PERCEIVED SOCIAL AND INDIVIDUAL BENEFITS OF THE ICCM INTERVENTION IN KUCHALACOURA BY AMINATOU (CHW)

Background

The iCCM activities started in Mali in 2020 to strengthen access to healthcare in remote areas. In Kuchalacoura, a site located 15 km from the Diabally Centre de Santé Communautaire (CSCOM), CHWs offer various services free of charge to children under 15 years of age and to women who have given birth. These services include screening and treatment of uncomplicated malaria, management of ARIs, treatment of diarrhoea, screening of malnutrition cases, referral of proven cases of severe malaria and malnutrition, monitoring of vaccinations, home visits for awareness-raising, community mobilization and post-natal consultations.

Health Worker Profile

Aminatou*, approximately 32 years old, has been a CHW since 2012. Having an early primary school level of education, she was able to show determination to obtain the Diploma of Nursing Assistant after passing a written test and following a 15-day training course in Niono. Driven by a desire to serve her community and reduce infant and maternal mortality, Aminatou has become a vital pillar of the local health system.[11]

Aminatou's work

Aminatou uses a variety of tools to provide quality care:

- **Diagnostic and treatment equipment**: A thermometer, a medicine cabinet, a scale and a consultation register allow for rigorous medical follow-up.
- **Screening tools**: Although the equipment dedicated to pneumonia testing has been down for two years and the referral sheets are insufficient, Hawa continues to follow up on cases.
- **Reporting tools**: Weekly and monthly summary sheets to report on activities and results achieved.

Challenges and constraints

Despite her commitment and skills, Aminatou faces many difficulties:

- **Insufficient equipment**: The lack of handwashing equipment, garbage cans, chairs and consultation tables limit the effectiveness of his intervention.
- **Security**: The presence of jihadists in the region imposes severe constraints, including the obligation for women to veil themselves completely under penalty of violence.
- **Difficult working conditions**: Covering a population of 19,000, Aminatou lacks torches, shoes, and suitable clothing during the rainy season.

[11] The names marked with a star * in all case studies have been changed for the purposes of this evaluation report. They can in no way be linked to the above-mentioned actors. In addition, the CHW referenced in Case study one provided signed informed consent.

- **Out of stock**: A month before the visit (November 2024), a stock shortage of the RDT lasted 15 days, impacting the continuity of her services.
- **Supervision**: The absence of MSF supervision on-site in the communities for more than a year due to security reasons, contributes to professional isolation and the difficulty of ensuring optimal follow-up. MOH health facility teams did provide supervision and report back to MSF.
- **Remuneration**: The financial motivation remains modest, limiting Aminatou's ability to invest in additional resources to improve its service.

Despite this, Aminatou sees a real personal benefit to being a CHW, due to the social recognition and skill strengthening through the continuous acquisition of new knowledge: **"***Before MSF support, I worked for free as a relay and now with MSF's support I have learned a lot through the trainings given by MSF on diseases that tire children. Currently, when I see a sick child, I can easily identify him or her and refer the parents to a health service.*"

Points for improvement

From this interview and other in-person site visits, the evaluation team identified three items to strengthen the effectiveness of the iCCM intervention in Koutchalacoura, including to:

- Provide missing basic materials (hand basin, garbage cans, chairs, consultation tables, torches, shoes and suitable clothing).
- Address the breakdown of pneumonia testing equipment and improve reference tools.
- Re-establish a regular supervision system, ideally with the support of organizations such as MSF, to ensure the quality and continuity of services.

Aminatou's experience illustrates the positive social and individual benefits of the iCCM intervention in a difficult context.

BENCHMARK 4: SUPPLY CHAIN MANAGEMENT

This benchmark assesses the systems and processes through which iCCM commodities—including appropriate 'child-friendly' essential medicines, diagnostics, and equipment—are procured, stored, and distributed. It examines procurement planning, inventory control, resupply logistics, and logistics management and information systems, and whether these include standard operating procedures. The benchmark also considers the inclusion of iCCM commodities in national essential medicines lists and the sustainability of supply chain practices to maintain consistent access to quality-assured medicines across MSF-supported sites.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (how iCCM is operationalized) • EQ3 (challenges in maintaining services) • EQ5 (sustainability)	• Reach • Effectiveness • Implementation • Maintenance

FINDINGS

As supply chain management (SCM) for iCCM activities relies on MSF-OCB's broader procurement system, it generally ensures access to quality diagnostic and essential medicine supplies. **Stable resupply systems were reported in several project sites**, supported by monthly deliveries, emergency replenishment mechanisms, and coordination between pharmaceutical and supply teams and health authorities. In Masisi, CHWs were resupplied weekly based on consumption through the health zone pharmacy, and the MSF pharmacy maintained consistent stock at the zonal level. In Kebbi, supervisors conducted monthly reconciliations between patient registers and drug usage, helping improve consumption tracking and anticipate restocking needs. Additionally, one supply manager in Kenema shared, *"Normally they receive supplies monthly... if there is a delay or a stockout, there is a communication to see how we can ensure the CHWs receive the supplies they need."* These examples underscore the potential of coordinated systems to build reliability and strengthen community confidence in CHWs as trusted providers of care.

However, this **level of consistency was not universal**. In Cibitoke, Burundi, and Niono, Tombouctou, Mali stock-outs were noted, sometimes lasting a significant amount of time, caused by a combination of infrastructure challenges, limited access to storage facilities, and coordination gaps between district health offices and health facilities. In Cibitoke, facility staff at times hesitated to release supplies to CHWs, and agricultural responsibilities prevented CHWs from collecting stock when it was available. In EGPAA, the geographic dispersion of CHWs made it difficult to coordinate resupply without reliable transport or defined contingency protocols. These challenges suggest a need for clearer logistics planning and shared accountability between MSF, MOH actors, and health facility personnel.

Document review findings also highlighted **weaknesses in contingency planning**. While most projects used structured supply calendars and forecast models, sudden scale-up—such as the opening of new treatment sites or expansion of seasonal malaria chemoprevention—often led to short-term shortages. In Tombouctou, the introduction of new community health posts strained existing supply chains, requiring emergency redistribution from nearby locations. Although inter-site transfers and buffer stock reallocation helped mitigate immediate shortages, these reactive approaches exposed gaps in proactive stock forecasting.

Storage practices also varied. In most sites, CHWs stored medications in backpacks at home, with some using locked trunks or community-owned storage managed by community leaders. While safety and drug quality were not commonly raised as concerns, clearer storage guidelines to protect supplies from the elements and to ensure safe storage away from any potential access by children as well as more consistent access to secure containers could enhance drug security and handling practices. In places like Kebbi, supervisors conducted monthly drug and patient register reconciliations—a promising approach that the evaluation team views as an example of effective supervision that could be scaled across other sites.

A persistent concern across multiple contexts was the **scalability and long-term sustainability of supply chain systems**. In many projects, MSF remained the primary actor in procurement and distribution, with limited government engagement in forecasting, ordering, or inventory tracking. In Niono, MOH staff expressed uncertainty about how stock would be maintained post-MSF exit. In Kebbi, staff voiced concerns about reliance on external funding and the absence of government forecasting systems for iCCM commodities. As one coordinator in South Sudan explained, *"Long-term hope lies in UNICEF's ability to secure a larger budget… MSF cannot do this alone forever."* The evaluation team interprets this as a reflection of the need for stronger national-level collaboration and transition planning. In some sites, facility staff and managers were **unclear on whether a plan existed for maintaining iCCM supplies once MSF support ended.** This is particularly challenging as in cases where current iCCM sites are linked to health clinics managed by MSF-OCB teams so when MSF funding ends both the clinic and iCCM activities will end, often without a feasible transition plan with MOH and partners. This lack of visibility risks service interruptions and may undermine the gains made during implementation.

Despite these challenges, **MSF teams have shown innovation and responsiveness in adapting to local realities**—whether by adjusting delivery quantities for hard-to-reach areas, involving community leaders in logistics planning, or reinforcing supervisor-led inventory checks. In Masisi, CHWs participated in participatory planning for medicine quantities based on seasonality, while in Tombouctou, local transport providers were engaged to help deliver drugs to remote CHWs during the rainy season. Moving forward, more formalized collaboration with MOH and global partners, targeted investment in CHW logistics support, and improved data sharing across sites will be essential to ensure that iCCM services remain consistent and responsive, particularly in fragile and underserved settings.

RECOMMENDATIONS

To enhance supply chain resilience, scalability and sustainability, evaluation findings identify several concrete actions. First, **site-specific iCCM logistics plans should be developed to anticipate bottlenecks and ensure timely resupply in hard-to-reach areas.** These may include pre-positioning commodities, engaging local transportation networks, and ensuring buffer stocks for CHWs operating in remote zones. In Yei, for example, delivering larger quantities to CHWs in remote areas reduced the burden of frequent restocking and could be standardized across similar contexts.

Second, **formalized pharmaceutical and supply roles and responsibilities must be established and coordinated among MSF, MOH, and CHWs**, supported by joint planning sessions and integrated accountability frameworks. Clear expectations for drug handover, facility stock release, and CHW refill schedules should be outlined in Memoranda of Understanding (MOUs) with health district teams. Coordination with health facility staff, as seen in Kenema, where supplies are delivered directly to communities upon request, could serve as a model.

At the national level, MSF should share experiences with other supply chain management partners where appropriate and advocate for the strengthening of government procurement capacity. Preparation for the eventual transitioning of responsibility for iCCM commodity management to MOH actors will be essential. Where feasible, MSF should support governments to integrate iCCM commodities into national essential medicine lists, LMIS, and forecasting cycles. Early engagement with actors such as UNICEF and the Global Fund may help facilitate this handover process.

MSF can also **align its support to reinforce iCCM stock tracking systems**, including early warning indicators to help mitigate disruptions, particularly in fragile or volatile areas. Supervision tools—like those used in Kebbi to cross-check drug and patient registers—should be incorporated into routine M&E systems to identify discrepancies and support training.

To improve medicine quality and handling, MSF should **standardize guidance on secure, weather-resistant, and child-safe storage solutions**. In Yei and South Sudan more broadly, CHWs stored supplies in locked metal boxes managed by supervisors or local chiefs. Developing minimum criteria for CHW-level storage—such as being lockable, dry, elevated from the ground, and inaccessible to children—will reduce risks of spoilage, misuse, or injury. Where metal trunks are not feasible, MSF should pilot alternative portable, waterproof containers.

Training on drug security and inventory management should be expanded across sites. In Cibitoke, reports of stock being withheld at facilities and inconsistencies in resupply underscore the importance of refresher training for both facility staff and CHWs on roles, transparency, and shared accountability.

MSF should also **ensure that child-friendly formulations**—such as dispersible tablets, flavored oral rehydration salts (ORS), and appropriately dosed zinc supplements—**are prioritised in procurement and distribution planning**. This aligns with WHO/UNICEF guidance and responds to reported challenges with treatment adherence in younger children.

Finally, **scalability and sustainability planning must be embedded into project design from the outset**. As seen in South Sudan and Niono, the lack of clear transition plans created uncertainty and reduced

confidence among facility staff. Projects should be urged to draft a supply scale-up and transition roadmap during initial planning stages, detailing how procurement, storage, and reporting will be scaled across iCCM sites and handed over to MOH or other actors over time.

BENCHMARK 5: SERVICE DELIVERY AND REFERRAL

This benchmark evaluates how effectively iCCM services are delivered and how referral systems are implemented across MSF-supported sites. It includes the comprehensiveness of the service package, the consistency of clinical protocols, and the functioning of referral and counter-referral pathways for cases requiring more advanced care. It also assesses whether appropriate guidelines exist for clinical assessment, diagnosis, management, and rational use of medicines (including RDTs where applicable). The benchmark further explores equity of access and the extent to which service delivery meets the needs of diverse and underserved populations.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (components and decisions on service delivery) • EQ3 (access, quality, and challenges) • EQ4 (recommendations for effectiveness and reach)	• Reach • Effectiveness • Adoption • Implementation • Maintenance

FINDINGS

Service delivery and referral systems were central to the accessibility and quality of iCCM interventions across MSF-OCB projects, with CHWs playing a key role in delivering timely care and linking patients to facility-based services. Findings from KIIs found that, in many contexts, MSF teams successfully tailored iCCM packages to local needs—integrating components such as nutrition, maternal health, or immunization alongside the core package of malaria, diarrhoea, and ARI diagnosis and management for children under five.

In Kenema and Yei, for example, CHWs followed structured protocols supported by visual job aids, regular supervision, and training materials aligned with MOH guidelines. Community feedback informed annual planning, and local leaders actively supported service delivery monitoring. These efforts contributed to high levels of community trust in CHWs and facilitated early treatment in remote areas.

In Niono, a planned community management board was being developed to reinforce community ownership and accountability for service delivery activities.

In EGPAA, CHWs were also trained to refer suspected cases of malnutrition and gender-based violence (GBV) to designated partners, even though services were not formally integrated. For GBV, CHWs acted primarily as referral points rather than service providers. They identified and referred survivors to MSF-supported health facilities where clinical care for sexual violence (SV), including post-exposure prophylaxis and psychological support, was available. CHWs were not involved in providing direct care for GBV cases but played a role in early identification and safe linkage to care, particularly in remote areas where facility access was limited.

The project site in Tombouctou represents a hybrid model of iCCM that differs substantially from both the national "*Stratégie des Soins Essentiels dans la Communauté*" (Stratégie des SECs) approach and other MSF-supported interventions. Rather than focusing exclusively on under-five children or a restricted set of illnesses, the intervention in Tombouctou treats all age groups and a broader range of approximately ten pathologies. While ReCos play an important role in awareness-raising and referrals, they do not provide direct case management. Instead, the frontline of service delivery is provided by ASC sites—a model of care at the community level that is not iCCM, but rather advanced health posts staffed by a nurse and a matron. These sites act as decentralized outposts delivering basic care and prevention services, and referring more complicated cases as needed. As described by one MSF staff member, "*We are unique in having "Agent de Santé Communautaires" (ASCs). We want to provide decentralized care at the lowest level of the decentralized chain... That said, the iCCM that we perform here is not really iCCM.*" This model, which blends facility-based care with community-level outreach, highlights the importance of complementing the standard iCCM package with additional community-based strategies—such as care delivered by nurses or other cadres—to address context-specific barriers to access. Rather than redefining iCCM, these adaptations should be understood as separate, yet coordinated, efforts to extend the reach of care in challenging geographic and health system contexts.

However, the evaluation found inconsistencies in the scope and standardization of services across sites. In some areas, such as Masisi and Cibitoke, gaps remained in integrating ARI diagnosis and management due to concerns about diagnostic complexity, resource availability, or alignment with national policy. In Masisi, proposed expansion of CHW tasks to include pneumonia diagnosis was postponed during the COVID-19 pandemic, and many CHWs reported lacking respiratory timers to reliably assess fast breathing. This variability in service scope, alongside the absence of a harmonized MSF-wide technical framework, resulted in differing standards of care across projects. The evaluation team interprets this as an opportunity for MSF to introduce clearer guidance for service integration while retaining the flexibility needed to adapt to local realities.

Adapting iCCM to Local Realities: Implementation in Practice.

Implementation fidelity varied widely across MSF-OCB project sites, reflecting both contextual challenges and intentional adaptations. Most teams conducted situational assessments and community consultations to tailor the iCCM model, adjusting disease coverage, age groups served, and delivery modalities. In sites like Tombouctou, services extended beyond the standard package to include adult care, mental health, and in Masisi where traditional birth attendants may provide information and referral for those affected by sexual violence. In Tombouctou, these adaptations responded to gaps left by other NGOs withdrawing from the area, with CHWs also engaged in wider outreach during seasonal malaria chemoprevention campaigns. In Masisi, *relais communautaires* (ReCos) collaborated with traditional birth attendants to strengthen maternal referrals, and community leaders supported local medicine storage solutions to improve accessibility. However, implementation faced barriers such as unclear national alignment, limited resource availability, and differing levels of collaboration with health authorities. Across all sites, flexible, context-driven adaptation was a hallmark of iCCM delivery—critical for reaching underserved populations while also raising questions about standardization and accountability across the MSF portfolio.

Referral systems were recognized by project teams and communities as a critical pillar of the iCCM model. In several settings, CHWs demonstrated strong ability to identify severe cases and initiate pre-referral care—such as the administration of rectal artesunate (RAS) for suspected severe malaria or ORS for diarrhoea. In Yei, CHWs used a structured referral process with dedicated forms and dual copies shared between health facilities and CHWs. In Kenema, referrals were also documented systematically, but the absence of transport support and facility-based feedback loops created major bottlenecks in closing the referral loop. In Tombouctou, referrals were often discouraged by caregivers who feared long travel times and the indirect costs associated with facility-based care. To help address this challenge, a modified community approach has been implemented—where a nurse rather than a CHW provides care at the community level and treatment is offered to all age groups. While still limited in scope, this model may help reduce the number of cases requiring referral. It also reflects efforts to adapt service delivery to contextual needs, aligning with a more people-centred approach. Nonetheless, the practical challenges of completing referrals were significant. Across many projects, patients faced long travel distances, limited transport options, high out-of-pocket costs, and risks due to insecurity or poor road conditions. In Yei, families sometimes sold livestock to afford transport, and in Masisi, referrals could require hours of walking across difficult terrain. As one MOH provider noted, *"There is no funding from the MOH for transport—CHWs sometimes accompany patients for long distances, but they are not compensated."*

These challenges were compounded by weak referral tracking systems. While referral forms and registers were used in most sites, follow-up documentation and outcome monitoring were often inconsistent. Quantitative data further confirmed that **on average, less than 50% of referred patients reached the intended facility**—a figure that underscores the need for more robust referral tracking and community-

based follow-up mechanisms. In Yei and Masisi, community leaders were engaged to support referral awareness, and project teams reported progress in organizing local follow-up. However, these practices were not yet systematized across all projects. In Kebbi, referral outcomes were not consistently recorded, and some CHWs reported difficulty convincing caregivers to follow through with referrals due to stigma or mistrust of health facilities.

The evaluation also noted that **service coverage was uneven** in some contexts, particularly in areas affected by NGO withdrawal or population shifts. In Tombouctou and parts of Mali, coverage gaps persisted due to insufficient staffing or outdated population data. In Kenema, adolescents and persons with disabilities were identified as under-represented in-service use, and outreach to these groups remained ad hoc. While the primary focus of iCCM is on children under five, some coordination and project staff in EGPAA, South Sudan, noted that broader community health activities did not sufficiently account for the needs of certain marginalized groups—such as people with disabilities and LGBTQIA+ individuals. These groups were not actively included in health promotion or outreach strategies, representing a missed opportunity for equity in community engagement and service delivery planning, particularly in rapidly changing or conflict-affected settings.

Despite these challenges, CHWs were widely seen as effective and compassionate providers. Their ability to combine service delivery with health education—often through informal talks in homes, markets, and churches—strengthened both individual care and community awareness. However, their effectiveness was sometimes constrained by a lack of basic tools (e.g., respiratory timers), limited waste disposal options, and competing personal responsibilities. In Cibitoke, CHWs reported storing drugs and patient registers in plastic bags or improvised containers during the rainy season, raising concerns about stock loss and data quality. As one advisor in Yei observed, CHWs often balance patient care in the morning with farming or other work in the afternoon—underscoring the need for flexible scheduling and consistent support.

Overall, MSF's approach to iCCM service delivery and referral has increased access to care in difficult settings (Annex 11, Graphs 11.1, 11.2, 11.3, 11.4 and 11.24). Moving forward, the evaluation team sees a **valuable opportunity to reinforce these gains by introducing a standardized technical framework, enhancing referral pathways through local partnerships and transport support, and ensuring that service expansion strategies are guided by equity and inclusion.** Projects like Masisi and Niono show that even basic tools—such as laminated job aids, stock control books, and clear referral steps—can greatly improve service consistency and CHW confidence when appropriately tailored and reinforced through supervision.

Improving Health Outcomes Through Tailored iCCM Approaches.

As demonstrated in the increase in new consultations, with the largest share of the increase in children 12-59 months, in project sites with iCCM activities from 2022-2024 (Annex 11, Graphs 11.1 and 11.2), MSF-OCB iCCM interventions have contributed to improving access to care for children in underserved settings, aligning with MSF's strategic objectives to reach populations with limited healthcare access. In South Sudan, iCCM functioned as a key community-level strategy in areas with severely limited health infrastructure, helping to ensure a basic package of care was available at the community level where few alternatives existed. In Sierra Leone and Mali, models were adapted to local contexts—for example, frontline ASC sites which act as advanced health posts staffed by a nurse and a matron.

Key informants indicated that in most project sites, CHWs remained trusted providers, supported by targeted training and supervision, though challenges like literacy barriers, limited referral capacity, and inconsistent supply chains persisted. Projects like Kenema and Yei demonstrated how community trust, context-adapted capacity-building, and multi-level supervision structures, such as regular field-based mentorship by supervisors, joint supervision visits with MOH staff, and periodic oversight from coordination-level staff, can strengthen the perceived quality and reach of iCCM services.

RECOMMENDATIONS

To improve the quality and consistency of service delivery, **MSF should develop a specific standard iCCM technical toolkit which allows for flexibility to respond to national iCCM guidelines and contextual needs**. The toolkit should include MSF-OCB specific standardized guidelines drawing on global best practices and tools, standardized case management algorithms, diagnostic tools, training manuals, supervision checklists, and job aids. The aim is to develop tools that are fit-for-purpose within MSF operating contexts and can be adapted as needed based on MOH guidelines and contextual realities. This should draw on global guidance, such as the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) and iCCM toolkits and ensure inclusion of key community-level treatment and referral protocols for malaria, diarrhoea, pneumonia, and malnutrition, as well as integration of RDTs and mid-upper arm circumference (MUAC) assessments where appropriate.

CHW training, supervision, and performance monitoring systems should be both strengthened and streamlined through refresher training—particularly with literacy-sensitive tools and supervision—and improved infrastructure, such as secure storage and infection prevention materials. Scheduling flexibility and adequate compensation should be prioritised to ensure that CHWs can balance community health work with their personal responsibilities.

This toolkit should also include harmonized MSF guidance for project teams considering the integration of complementary services, such as safe motherhood, community-based management of acute malnutrition (CMAM), or GBV care, where feasible and aligned with national policy. As the rate of referral completion, the percentage of referred children who were received at health facilities, was highest in

Kenema (Annex 11, Graph 11.24) this may suggest that dedicated programs with a focus on referral linkages to MOH or other functional primary health facilities and hospitals (Table 2) are a successful avenue for further exploration. Teams should be encouraged to document adaptations and pilot integration models where CHW capacity and local partnerships allow.

To reinforce referral systems, MSF should consider partnerships to provide support for transportation for patients and CHWs where possible; the introduction of standardized referral and counter-referral form; and piloting mobile tracking tools or real-time referral monitoring mechanisms. Referral forms and follow-up systems from Yei and Masisi—where dual copies are shared between CHWs and facilities—can serve as a baseline model. Mobile-based tools or SMS tracking systems could help fill data gaps and confirm whether patients reach referral points and receive treatment. Community-based transportation initiatives and engagement with local leaders may also improve referral uptake. In locations like Niono or Tombouctou, linking referrals to community-managed emergency funds or locally coordinated transport (e.g., motorbike pools) may be viable.

To enhance equity, MSF should review and update project level needs assessments to identify service gaps and ensure that underserved groups, including marginalized populations, are reached. While the standard iCCM package remains focused on children under five with malaria, diarrhoea, and pneumonia, additional community-based activities can be considered to address unmet needs in specific contexts. In line with MSF-OCBA's Decentralized Models of Care (DMC) approach, MSF may complement iCCM with flexible, context-specific strategies at the project level. These may include mobile outreach, temporary clinics, or home-based care targeting other vulnerable groups such as older children, adolescents, or people with disabilities, where there is demonstrated need and feasibility. For example, in Tombouctou and Cibitoke, project-level strategies could include extending coverage through seasonal campaigns or temporary outreach sites, guided by micro-census updates and population movement tracking. Such adaptations should be clearly distinguished from iCCM and understood as part of a broader community-based or primary health care strategy, ensuring that the core iCCM package remains focused on its evidence-based scope.

CHW support systems can be strengthened through refresher training—particularly with literacy-sensitive tools and supervision—and improved infrastructure, such as secure storage and infection prevention materials. A refresher training package can include simplified documentation tools, stock tracking forms, and clear visual guides. Peer learning and coaching, used successfully in Masisi and Yei, should be scaled where possible. Scheduling flexibility and adequate compensation can be prioritised to ensure that CHWs can sustainably balance community health work with their personal responsibilities. In EGPAA and Kebbi, task loads, and farming duties compete with CHW roles—adjusting schedules and increasing stipends would enhance long-term retention and performance.

Finally, MSF should prioritize coordination with MOH and other partners to align service delivery and referral practices with national plans and ensure scalability and long-term sustainability. This includes joint planning for training, harmonization of referral protocols, and shared supervision approaches—such as the "*train-the-trainer*" models and community follow-up practices seen in Yei and Kenema.

CASE STUDY 2: IMPROVING ACCESS TO HEALTHCARE AND HEALTH SERVICES FOR CHILDREN UNDER FIVE IN LAST MILE COMMUNITIES (CATTLE CAMPS IN MAMBISHA AND NOERS) IN EGPAA -SOUTH SUDAN

Context

In the remote cattle camps of EGPAA, notably Mambisha and Noer, access to healthcare has been a continual challenge, with high child mortality rates due to malaria, diarrhoea, and respiratory infections. These cattle camps are located around 65 km from Maruwa and have a population of around 10,000 during the dry season. These camps are accessible by a makeshift road that is not used by vehicles other than MSF vehicles. Most of the inhabitants of Lazanch walk to Maruwa, the nearest town with an MSF health facility. The journey takes two to three days.

Before 2022, these communities experienced severe outbreaks, including a diarrhoea epidemic among cattle keepers, leading to numerous child deaths. In response, the iCCM initiative was introduced by MSF to improve access to essential healthcare services for children under five.

Implementation

Since 2022, three Community Health Agents (CHAs) have been providing critical healthcare services targeting children under 5, in the cattle camps (Mambisha and Noer). Their roles and responsibilities include:

- **Testing and treating malaria cases** (all ages) using rapid diagnostic tests and antimalarial drugs.
- **Managing diarrhoea cases** through oral rehydration therapy and zinc supplementation.
- **Detecting respiratory infections** with appropriate antibiotics.
- **Conducting health education sessions** to raise awareness about disease prevention and hygiene practices.

Effects of iCCM interventions

According to caregivers' testimonies, the introduction of iCCM in cattle camps has led to remarkable improvements in child health, including improved access to treatment and health awareness and disease prevention, contributing to long-term health improvements.

The testimonies highlight the positive effect of the intervention in the village. Many have reported that timely access to medicine has saved their children's lives and reduced the severity of illnesses. Without the CHAs, many families would have to travel long distances or go without treatment.

"When my child, who is four years old, had severe diarrhoea.... I took her to the community health worker. He gave her oral medication and my child was relieved. That is when I realised that these people (CHA) really help us. Without this service, we did not know what to do. Now the child is well" (Geho*, 23 years old, four children, two children under five)

"*We normally go to the community health agent when our children are having fever, diarrhoea...and we get satisfaction*" (Machimeri*, 21 years old, one child under five)

"I had the case of my child who could not breathe well and was vomiting. I took him to the community health agent and he got better" (Djoubeiro*, 20 years old, one child under five)

"*Now there is a big change in our community compared to what we had in the past, before MSF came. Before, if a child was sick, we had to take them to Maruwa or use herbs. We had some children who died. Now things have changed. We have medicines in the community and children no longer die as they used to*". (Pontcho*, 35 years old, six children and three under five)

BENCHMARK 6: HEALTH PROMOTION AND COMMUNITY ENGAGEMENT

This benchmark explores how iCCM health promotion and community engagement (HPCE) efforts engage communities to increase health awareness, encourage care-seeking, and support CHW service delivery. It includes an assessment of HPCE plans and strategies; the relevance and accessibility of iCCM-specific materials and messages; coordination with MOH and local leaders, and the degree to which communication is inclusive, context-tailored, community-owned, scalable and sustainable.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (community involvement in project design) • EQ3 (lessons learned) • EQ5 (community ownership and sustainability)	• Reach • Effectiveness • Adoption • Implementation • Maintenance

FINDINGS

Health promotion and community engagement were consistently highlighted as both a key strength and an area of opportunity within iCCM implementation. Across KIIs with MSF-OCB projects, staff shared that **CHWs played a central role in engaging and mobilizing communities** through trusted, localized health messaging delivered in churches, markets, and during community gatherings. Visual tools like flip charts, posters, and image-based guides developed by MSF Health Promotion teams, were widely used and appreciated, particularly in settings with lower literacy levels. In sites like Kebbi and Cibitoke, the use of flip charts and simplified instruction guides made complex health information more accessible, while in Yei, community meetings and local radio broadcasts significantly expanded message reach. In Cibitoke, mass sensitization campaigns focused on malaria, diarrhoea, and hygiene using "*boîte à images*" and flip

charts helped reinforce key health messages. In Kebbi, locally adapted job aids—such as salt-sugar solution preparation instructions and MUAC screening guides—were co-developed by CORPs and community leaders to enhance understanding and usability. These strategies reinforced CHWs' visibility as health leaders and supported uptake of iCCM services.

Projects also benefited from community-led engagement and mobilization efforts, including the provision of physical space for health education, grassroots dissemination of health messages by local leaders, and the use of informal platforms like funerals or ASACO meetings to raise awareness. For example, funerals bring together people from different communities. During wakes, the CHW teams say they seize every opportunity to raise awareness in the community. In some cases, communities even contributed infrastructure or transportation to support CHW work—examples of the deep trust and ownership built through effective community engagement. In Niono, ASACO committees met quarterly to discuss health issues and propose community-led solutions, facilitating two-way communication between CHWs and the population. These collaborative approaches created a sense of shared purpose and were especially effective in increasing awareness of preventive care and danger signs.

However, the evaluation also identified important gaps - notably the lack of clear health promotion and community engagement plans for iCCM. In most settings, **HPCE strategies were instead driven by project level adaptations and lacked a structured framework to guide planning, coordination, and monitoring**. As a result, HPCE activities were often opportunistic—conducted during supervision or when time allowed—rather than based on a systematic schedule. The absence of a unified communication plan or HPCE TOR for CHWs, MOH partners, and community leaders resulted in fragmented HPCE implementation and inconsistencies in message delivery to communities and caregivers. A health promotion supervisor in one project site noted, *"The strategy is a challenge from the start. It all starts with exploration and a good understanding of the context."* Although ReCos in Masisi were trained to raise awareness of the three key iCCM pathologies (malaria, diarrhoea, ARIs) and underlying nutrition, health promotion efforts were reported to rely heavily on individual ReCos' initiative, with few standardized tools or schedules in place. The evaluation team interprets this as a call for clearer strategic direction to reinforce scalability, sustainability, and standardization across sites.

Findings from the document review highlighted further **variability in the roles of community structures, MOH collaborators, and health promotion teams**. While some settings reported strong participation from religious institutions and women's groups, others faced inconsistent engagement from local leaders or lacked dedicated communication resources. In several contexts, outreach was limited by geography, insecurity, or a lack of culturally relevant materials. Vulnerable populations—such as nomadic groups, people living in extreme poverty, or marginalized identities—were often less likely to be reached by standard messaging approaches or outreach limited to existing community leadership structures, which may not recognize the poor or marginalized. This reinforces the importance of understanding the context for these groups within the broader landscape of the communities present, and tailoring MSF's approach to identified barriers. Fragmentation of HPCE strategies reduced the overall reach and effectiveness of health education efforts, and the evaluation team believes that a more intentional focus on inclusion and adaptability would help bridge these gaps. In EGPAA and Tombouctou, CHWs reported challenges in

reaching mobile populations and expressed a need for audio-based or oral messaging methods, such as messaging through vehicle radios, that could accommodate low-literacy, linguistically diverse groups.

Despite these challenges, **the strong foundation of community trust, innovative outreach tools (e.g., mobile loudspeakers, participatory forums), and growing use of local media channels offer promising entry points for expansion.** CHWs' use of mobile phones for real-time communication and data sharing further strengthened coordination, while the growing involvement of youth and female leaders in some areas signalled an emerging opportunity to diversify health promotion voices. In Yei, posters were cited as an effective tool for reaching populations without radios, while mobile loudspeakers and radio discussions tailored by local leaders helped increase demand for iCCM services. In Kenema, however, gaps in early training for health facility staff created friction in referrals and service alignment, underscoring the need to link communication strategies to both community and facility actors. In areas like Yei, where demand for structured health education was increasing, there is a clear appetite to scale and institutionalize communication as a core component of iCCM.

Moving forward, MSF can **build on these successes by developing a formal, adaptable health promotion and community engagement strategy** that centres local voices, aligns with national health promotion plans, supports scalability and sustainability through stronger MOH integration and shared accountability mechanisms.

Ensuring linkages of iCCM with health facilities.

Support of the iCCM approach among health facility staff varies depending on training coverage and alignment with existing health programmes. In Kenema, Sierra Leone, for example, initial gaps in training meant that some facility staff were unfamiliar with iCCM protocols, leading to misunderstandings about CHWs' roles, treatment responsibilities, and referral processes between CHWs and PHU personnel. Over time, training efforts have improved, with more than 80 percent of facility-based staff now familiar with iCCM services.

RECOMMENDATIONS

To strengthen health promotion and community engagement for iCCM, MSF-OCB should **develop a standardized yet flexible strategic framework and evidence-based tools** that allow for local adaptation while setting expectations across iCCM stakeholders for health messaging. This strategy should include guidance on engaging with community members (including marginalized populations) from the inception of iCCM planning, to incorporate their inputs and co-create HPCE strategies and activities which meet their priority needs and address key determinants of healthy behaviours. The strategy may also include advice for and examples of low-literacy materials, participatory content development, and inclusive communication channels that reach remote, mobile, or marginalized groups. Materials such as image-based flip charts, simplified treatment guides, and audio scripts—successfully used in Cibitoke and Kebbi—can be consolidated into a shared resource library and adapted based on project needs.

Training should be expanded for CHWs and community leaders, equipping them with communication and health promotion skills tailored to their specific roles. Regular supervision and feedback mechanisms should be implemented to improve message delivery and assess effectiveness over time. In Masisi, where health promotion efforts are often improvised, more structured outreach planning can reinforce CHW HPCE. Supervision sessions should include opportunities for peer-to-peer review of communication practices, community feedback loops, and updates to health education messaging and approaches based on seasonal or epidemiological shifts.

Enhanced collaboration with MOH structures is essential to ensure continuity and institutionalization of health promotion efforts beyond MSF's support. Joint outreach and message harmonization with MOH teams—as piloted in Kenema and Niono—should be formalized through coordination protocols, particularly where referral linkages or community trust in health facilities remains fragile. Development and dissemination of a clear TOR for the roles of CHWs, MOH collaborators, and community leaders in health promotion would also support alignment and accountability.

Where feasible, **MSF should invest in digital tools, mobile outreach systems, and leverage inter-agency coordination platforms** to scale and harmonize health education messaging. Projects like Yei, which have experimented with radio spots and mobile loudspeakers, highlight the importance of multimodal outreach—especially in settings with dispersed populations and limited internet or mobile penetration. A small investment in items such as community radios could enable ongoing messaging even in fragile, off-grid contexts.

Promoting community-led health promotion initiatives and integrating them into broader service delivery frameworks will further reinforce scalability, sustainability, and impact. In Niono, the active role of ASACO committees in organizing health dialogues shows the value of community governance in communication planning. MSF should explore formalizing similar feedback mechanisms across sites, ensuring communities have a voice not only in content but also in format, language, and delivery methods. Scalable, sustained impact will require building community ownership into the foundations of iCCM—through local champions, integrated planning, and regular community monitoring.

CASE STUDY 3: BRINGING HEALTH HOPE IN THE HARD-TO-REACH COMMUNITY OF IN NAOYOPWE – THE EXPERIENCE OF NAMOR (CHA)

Context

Naoyopwe is an isolated village located 21 km from the centre of Boma, South Sudan. The only access route is extremely treacherous, requiring a two-hour drive by car. In such a remote area with limited access to healthcare facilities, the iCCM was introduced to address the local healthcare challenges. Years back before MSF iCCM interventions many people were suffering, and children were dying of malaria, malnutrition, and other diseases on the way to Boma.

Profile of the Community Health Agent

In July 2023, Namor*, a 35-year-old woman, was selected by her village chief to serve as the CHA for malaria test and treat and in June 2024 MSF implemented ICCM full packages in Koradep/Naoyape and Kosidria villages. Despite being illiterate, Namor received specialized training from MSF. Through this training, she acquired the essential skills needed to provide critical healthcare services to children under five years old.

Namor's work as CHA

As part of the iCCM initiative, Namor* was trained for the ICCM full package and the training was more on the practical part due to the illiteracy. She is managing top morbidity including malnutrition screening in Naoyape/Koradep village and referred patients with severe symptoms to MSF primary health care (PHC) centre. She is responsible for:

- Screening and treating uncomplicated malaria
- Treating diarrhoea
- Monitoring child vaccinations

Namor is available around the clock to attend to her community's urgent healthcare needs. To support her work, she uses educational tools such as picture boxes for health education sessions and a collar (a locally used tool for communication or monitoring). However, she faces challenges due to the lack of a thermometer to accurately measure children's temperatures during consultations. To restock supplies and for her monthly incentive payment, Namor must walk up to 21 km from their villages to MSF offices in Boma, carrying medicine boxes weighing up to 10 kg on their heads, which takes at least three hours.

Outcomes

Namor's efforts have led to several positive perceived outcomes:

- **Improved health knowledge:** Community members are increasingly adopting better hygiene practices, which help prevent diseases.
- **Enhanced community trust:** The prompt and effective care provided by Namor has significantly increased the community's confidence in the local healthcare system.

These outcomes clearly demonstrate the tangible benefits of the iCCM model in improving healthcare access in remote areas.

Challenges and Perspectives

Despite the successes, several challenges remain:

- **Insufficient remuneration:** Namor receives only US$50 per month from MSF. However, the time she dedicates to community activities prevents her from engaging in other income-generating activities and providing for her family.
- **High workload:** Her commitment to being available 24/7 leaves her little time for any alternative work.
- **Lack of basic equipment:** The absence of a thermometer hinders accurate assessment during consultations, especially when children have a fever.

Nevertheless, Namor's strong motivation, bolstered by community support and the benefits she observes in her community keeps her dedicated to her role. Additionally, she has gained valuable personal benefits from the training provided by MSF.

Namor's experience in Naoyopwe illustrates the important effect that an iCCM project can have in remote areas with limited healthcare access. Despite challenges such as inadequate remuneration and a lack of resources, community testimonials emphasize the importance of investing in CHAs[12], highlighting improvements in child health and increased community knowledge about health.

[12] The names marked with a star (*) in the above case studies have been changed for the purposes of this evaluation report. They can in no way be linked to the above-mentioned actors.

BENCHMARK 7: SUPERVISION AND PERFORMANCE QUALITY IMPROVEMENT

This benchmark assesses the systems and practices in place for supervising CHWs, ensuring quality service delivery, and supporting continuous performance improvement. It includes the existence of a supervision plan, the structure and frequency of supervisory visits, the use of standardized tools, mentorship and skills coaching approaches, and integration with MOH oversight systems. The benchmark also considers whether supervisors are trained and equipped with the resources (e.g., transport, fuel) needed to conduct effective supervision and examines how data is used to monitor and improve CHW performance and identify gaps in supervision coverage.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (supervision approaches used) • EQ3 (successes and challenges in quality assurance) • EQ5 (scalability and sustainability)	• Effectiveness • Maintenance

FINDINGS

Supervision and performance quality improvement emerged as a **foundational element in ensuring the effectiveness, consistency, and reliability of iCCM services** across MSF-OCB project sites. In settings like Yei and Kebbi, findings from **KIIs** showed that supervision structures were particularly well-established, combining standardized checklists, regular site visits, and collaboration with MOH counterparts. These **systems enabled real-time feedback, on-the-job mentorship, and data verification, reinforcing CHW confidence and adherence to protocols**. Supervisors in these sites used structured observation grids and data review forms to assess CHW activities, medicine usage, and referral compliance—models that demonstrated a link between supervision and service quality. Participants shared, for example, how reviewing the data helped them see where they were missing referrals, using drugs incorrectly, or to identify gaps in how CHWs were managing fever cases during home visits. In Yei, daily BHW supervision was carried out by MSF-contracted advisors (typically nurses or clinical officers with community health experience), while community service worker supervisors made at least two visits per month to correct CHW errors and provide feedback. Consultations with community leaders also helped identify service gaps, reinforcing accountability from both the community and health system levels. In Kebbi, MSF and MOH supervisors collaborated to assess case management, referral adherence, and stock levels across settlements, with findings consolidated into monthly reports that informed real-time project adjustments.

In contrast, other contexts such as Cibitoke operated with **less structured supervision, relying more on informal observations and community feedback**. While this approach supported flexibility, it lacked consistent documentation and **missed opportunities to systematically identify and address performance**

gaps. In Cibitoke, monthly supervision visits occurred without formal checklists, and feedback was delivered verbally, limiting the ability to track performance over time. However, these efforts were occasionally complemented by patient satisfaction surveys that offered community-level insight into CHW performance. The evaluation team interprets these differences as a clear indication of the value of investing in standard supervision protocols and ensuring their consistent application across sites.

Document review findings echoed these insights. While supervision grids and resupply meetings were common touchpoints, **many sites lacked an overarching supervision framework that clearly defined roles, visit frequency, and quality indicators**. In several projects, supervision focused more on activity volume than clinical mentoring. Limited supervisor training and high caseloads further constrained the ability to provide qualitative feedback and follow-up. These issues were compounded in hard-to-reach areas like Tombouctou or EGPAA, where insecurity and poor road conditions made in-person visits difficult. In Masisi, for example, supervision was harmonized with national protocols and carried out jointly by MSF and MOH, but insecurity in areas like Muheto and long travel distances limited the frequency of visits. Supervisors faced transport constraints and workload challenges, which restricted their ability to offer mentoring or in-depth case reviews. In such cases, CHWs often operated for long periods without support, raising concerns about protocol adherence and case management accuracy.

Encouragingly, **joint MOH and MSF supervision models showed promise in bridging these gaps**. In Yei, community service worker supervisors conducted bi-monthly visits. iCCM activities often received joint supervision visits from MSF and MOH teams, and CHWS generally report into MOH health facility in-charges. An MOH official in Masisi observed for example, *"Nothing can be done without the health system... SSCs [sites de soins communautaires, community health sites] should be supported through health centres."* In Kenema, a structured supervision schedule was in place, including bi-monthly individual visits and monthly group meetings, which helped reinforce training, identify skill gaps, and address data quality issues. The evaluation team believes that investing in health facility and district health authorities offers a scalable and sustainable path forward.

From the quantitative data, **challenges with data completeness and internal consistency also highlighted the role of supervision in ensuring data quality**. In sites with strong supervision systems, patient registers were regularly reconciled with medicine consumption logs, allowing discrepancies to be addressed and reinforcing CHW data literacy. In contrast, inconsistent documentation and stock tracking in less supervised areas hindered efforts to monitor project impact or identify service gaps in real time. In Niono and Tombouctou, supervision visits were sometimes delayed due to insecurity or resource limitations, and CHWs in remote areas reported going weeks without follow-up or coaching. Despite this, mobile supervision models and the use of WhatsApp groups allowed some projects to maintain periodic communication and case discussions.

Despite these challenges, **many supervisors demonstrated adaptability**—using mobile outreach, periodic team meetings, and even remote supervision (via phone) to **maintain contact with CHWs**. Monthly group sessions offered a forum for peer learning, while joint supervisory visits with MOH teams helped build alignment with national protocols and improve policy buy-in. In EGPAA, mobile visits were used to maintain follow-up of CHWs, especially in areas where roads were inaccessible during the rainy season. Supervisors reported that even with limited resources, outreach once or twice per week helped sustain

engagement and identify training needs. These examples show the potential for a hybrid model that combines structured tools, local adaptation, and digital solutions to strengthen supervision across contexts.

Moving forward, **MSF can build on existing strengths by scaling best practices from high-performing sites, supporting community-led supervision, and formalizing a standardized supervision package that can be adapted across operating environments.** Integrating mentorship and coaching into routine supervision, ensuring logistical support for supervisors, and reinforcing feedback loops between CHWs, communities, and project managers will be critical to maintaining high-quality, people-centred care.

RECOMMENDATIONS

To improve the consistency and quality of supervision, **best practices from sites with structured systems should be scaled across MSF-OCB**. Standardized tools such as supervision checklists, scorecards, and job aids should be deployed to guide evaluations and aggregate performance data. Integrating mentorship and coaching into routine supervision visits would shift the focus from compliance to quality improvement, supporting CHW growth and confidence. In Yei and Kenema, for example, the use of structured supervision plans that combine bi-monthly individual visits with monthly group sessions has been noted by participants as effective formats for reinforcing clinical skills and improving the quality of data collection. For example, one project staff member in Yei shared that "*the monthly group supervision helped CHWs understand better how to use the registers and gave them a chance to ask questions in a supportive space*." In Kenema, one supervisor noted that "*doing the one-one-one visits every two weeks helped [the team] catch mistakes early and correct them before they affected the reports*." Adapting similar supervision timetables across other sites—especially in post-training periods—can help standardize expectations and flag performance issues early.

To overcome access barriers in insecure or remote settings, **mobile supervision strategies and remote support via phones should be expanded**. CHW self-assessment tools and simplified supervision grids can further reinforce accountability in low-access zones.

Finally, **efforts should be made to systematize supervision within iCCM implementation frameworks**. This includes developing a shared technical supervision package, setting minimum frequency standards, and ensuring that supervisory findings are documented and linked to programmatic adjustments. Joint supervision visits with MOH representatives, as practiced in Kebbi and Niono, have also demonstrated added value by reinforcing alignment with national protocols and improving trust between CHWs and local health authorities. These collaborative approaches should be formalized in site-level planning and budgets to ensure continuity. These efforts will be key to ensuring the continued quality and resilience of iCCM interventions across diverse operational contexts.

BENCHMARK 8: MONITORING AND EVALUATION AND HEALTH INFORMATION SYSTEMS

This benchmark assesses how iCCM data is collected, analysed, and used to improve service delivery and project accountability. It focuses on the effectiveness of M&E frameworks; the integration of MSF data systems with national health information systems and the broader national health sector plan; the role of CHWs and communities in data processes; and the extent to which findings inform real-time decision-making and long-term planning. The benchmark also considers whether an operational research agenda exists to support the scale-up and continuous improvement of iCCM interventions.

Relevant Evaluation Question	Relevant RE-AIM Dimension
• EQ1 (data used for decision-making) • EQ3 (monitoring outcomes and challenges) • EQ5 (future alignment with national HIS)	• Reach • Effectiveness • Implementation • Maintenance

FINDINGS

M&E and HIS emerged as a foundational pillar for learning and improvement within MSF-OCB's iCCM projects. KIIs across multiple project sites highlighted the **strong commitment of project teams to structured data collection, demonstrated using standardized registers, DHIS2-compatible tools, and consistent reporting schedules**. Across project sites, supervisors and data stewards cross-checked patient registers with medicine usage records, providing an integrated picture of service delivery and strengthening supply chain monitoring. In Yei, a multi-tiered reporting system from CHWs to data supervisors ensured regular oversight, while in Masisi, quarterly analysis meetings informed real-time adjustments to project activities. In Kebbi, supervisors conducted drug stock audits alongside data collection from CORPs, with findings reported through structured pathways into DHIS2 and shared with both MSF coordination and public health authorities. In Niono, joint supervision visits by MSF and MOH staff included site-based discussions on performance trends and service delivery gaps, fostering stronger alignment with government reporting practices and encouraging a culture of shared accountability. These examples reflect how well-structured M&E systems can actively support data quality and responsiveness.

However, the evaluation also **highlighted persistent fragmentation across sites.** Many projects operated with **parallel reporting structures**—balancing MSF-specific logframes, national registers, and informal tools—resulting in siloed datasets that limit cross-comparability. The continued **reliance on paper-based systems** in several locations slowed data flow, introduced risk of reporting errors, and created barriers to real-time decision-making. While DHIS2 is used widely, its project-level customization and uneven implementation have reduced its effectiveness as a unified reporting platform. In locations like Cibitoke or Tombouctou, inconsistent data submission timelines and literacy-related documentation gaps further

undermined data reliability. In Kenema, although digital tools have been introduced, CHWs still collect data on paper and transfer it manually for upload, which delays data availability and increases the burden on supervisors responsible for validation. Staff also reported that parallel data entry systems complicated their ability to consolidate iCCM indicators across programmatic areas. In EGPAA, challenges related to staffing and limited supervisory capacity slowed the review of iCCM data and reduced the frequency of analysis-driven adjustments.

The evaluation team notes that **promising progress has been made toward digitization**. Projects like Kenema and Kebbi are piloting phone-based data entry and offline tools for remote CHWs. These systems improve timeliness, reduce transcription errors, and allow supervisors to provide quicker feedback. However, rollout is incomplete, and CHWs are rarely involved in data review and use processes. A technical advisor observed, *"CHWs collect the data, but it is sent up and not discussed. It's reported—but not really used locally."* This disconnect reduces opportunities for CHWs to use data to adapt their services or engage communities in identifying solutions. In Masisi, some ReCos were trained to produce visual summaries of patient caseloads, although these were not always integrated into formal health facility planning meetings. In Yei, although supervisors analyse data monthly and summarize it for coordination teams, this information is rarely fed back to CHWs or used in community discussions. As one focal point noted, *"Data is shared upwards but not returned in a way that CHWs or communities can understand or use."* This highlights a missed opportunity for closing the data loop at the frontline level.

Quantitative findings support this concern, highlighting **issues with data completeness, age disaggregation, and referral follow-up documentation.** In many sites, denominator estimates were outdated or unavailable—particularly in areas with high displacement or mobile populations—complicating efforts to assess iCCM coverage and equity. Moreover, **indicators like referral completion, danger sign identification, and malnutrition trends were often inconsistently tracked** across registers and data summaries. The evaluation team interprets these patterns as symptoms of limited capacity and underinvestment in data use for project learning. In EGPAA, the transition to the BHI model disrupted existing M&E routines, requiring the adaptation of registers and indicators mid-implementation. While staff expressed willingness to revise tools, the limited technical support available during this shift contributed to confusion and inconsistent reporting on iCCM-specific activities.

Still, across MSF-OCB project sites, **teams demonstrated innovation and resilience**. Supervisors in Masisi developed informal visual tools to provide feedback to CHWs. Community health workers in Yei used hand-drawn summaries to track trends in malaria or diarrhoea incidence. In Niono and Kebbi, MSF and MOH partners conducted periodic dashboard reviews to guide service adjustments. In Tombouctou, CHW supervisors noted that tally sheets were occasionally adapted to improve recording of referrals, although follow-up data remained incomplete in many cases. In Cibitoke, supervisors experimented with providing simple weekly summaries of common cases to CHWs using laminated cards, aiming to reinforce early recognition of danger signs. While this practice was not formally institutionalized, it demonstrated potential for low-tech feedback strategies that enhance frontline decision-making. These adaptations suggest strong potential for scalable, low-resource M&E solutions if formally recognised and supported.

A key challenge that cuts across projects is the lack of feedback loops to CHWs and communities. While data is routinely reported upward, it is not always shared back in formats that are accessible or actionable

for frontline workers or the public. This limits transparency and reduces the ability of local actors to take ownership of project activity improvements. The evaluation team believes that enhancing feedback systems, even simple visual dashboards or community meetings, would strengthen accountability and improve community trust in iCCM services.

Unlocking the Power of Data at the Community Level.

"CHWs collect the data, but it is sent up and not discussed. It's reported—but not really used locally." — MSF Technical Advisor.

Across project sites, community health workers play a critical role in gathering rich, frontline data. Building on this strong foundation, there is a clear opportunity to engage CHWs more deeply in reviewing and interpreting the data they collect. By strengthening feedback loops and providing user-friendly tools, MSF can transform routine reporting into a dynamic process that drives local action, supports service improvement, and reinforces accountability from the ground up.

RECOMMENDATIONS

To strengthen M&E and ensure scalable, sustainable integration into national health systems, several targeted improvements are recommended. First, **CHW and community involvement in data interpretation and use should be strengthened through training, simplified tools, and inclusion in regular review meetings**. This would support data ownership, enhance accountability, and enable CHWs to make local service improvements based on trends they observe. Examples from Masisi and Kenema show that visual summaries and simplified indicators can help CHWs understand patterns in malaria and referral adherence, even in the absence of formal dashboards. These strategies should be adapted and rolled out across projects to facilitate basic data literacy.

Second, **feedback loops must be improved to ensure data collected at the community level is shared back in accessible formats**. This could include visual dashboards, village-level reports, or regular community meetings where findings are presented and discussed. Creating transparency and reinforcing the value of data at every level can promote stronger community engagement and trust in the iCCM system. In Yei, supervisors reported that CHWs rarely receive any feedback from the monthly data reviews conducted at the project level. Institutionalizing simple feedback mechanisms—such as printed data briefs or community scoreboards—could help close this loop and reinforce CHW motivation.

Third, **the use of digital tools for real-time monitoring and decision-making should be expanded, with attention to low-connectivity contexts**. Offline-compatible mobile data collection apps or simple dashboard alerts could enhance responsiveness and improve data timeliness. Positive experiences from projects using mobile supervision and remote data review mechanisms suggest this is a viable avenue for scale-up. In Kebbi, for example, the introduction of phone-based data collection supported timelier

supervision and improved data accuracy. These systems should be evaluated for scalability and paired with basic digital literacy training for CHWs and supervisors.

Fourth, **MSF should continue aligning M&E and health information systems with national platforms such as DHIS2** to support scalability, sustainability, and government ownership. This includes working closely with MOH partners to ensure that data quality standards, indicators, and reporting processes are harmonized. Joint supervision and data validation visits with MOH—as piloted in Niono and Tombouctou—provide opportunities to ensure alignment and should be included in supervision planning and reporting protocols.

Building on identified good practices, it is also **recommended that MSF formalize some of the promising grassroots approaches already being used across project sites**. For example, informal community dashboards, stock-level checks aligned with CHW reports, and visual tools for patient tracking could be standardized and shared across contexts. Similarly, routine supervision visits that include joint data review and supportive coaching should be integrated into standard quality protocols. These low resource but effective adaptations can serve as scalable models to enhance data use in challenging settings.

Finally, **MSF should explore ways to strengthen offline data visualization and develop simple self-monitoring tools for CHWs**. Empowering frontline providers with user-friendly performance tools may help bridge gaps in formal M&E systems while improving local accountability and service quality. Promising tools from Cibitoke and Masisi, such as laminated case summary cards and CHW-developed tally visuals, suggest that CHWs can innovate when provided with basic materials and guidance. MSF should invest in streamlining and disseminating these practices as part of a standard M&E toolkit.

DISCUSSION AND NEXT STEPS

This evaluation assessed iCCM design, implementation, scalability, and sustainability across eight MSF-OCB projects, using the RE-AIM framework and the WHO-UNICEF iCCM programmatic benchmarks. Drawing from stakeholder interviews, FGDs, document review, case studies, and quantitative data analysis, the evaluation provides a multi-dimensional understanding iCCM adaptations across diverse humanitarian and health system contexts. This section synthesizes key findings and recommendations across the core evaluation questions and outlines strategic next steps.

EQ1–2: iCCM Design, Operationalisation, and Differentiation Across Sites

While the iCCM intervention package is broadly consistent—typically providing case management of malaria, diarrhoea, and (in some contexts) pneumonia as well as malnutrition screening and referral—the delivery strategies and operational models vary considerably. These differences reflect MSF's responsiveness to geographic, security, and infrastructural challenges, and population need. At the same time, they also underscore the absence of an MSF-OCB iCCM strategy guiding a common understanding of the design and implementation of iCCM activities across the continuum of care, as well as a lack of MSF-OCB specific operational norms and quality standards.

For example, in Tombouctou, an adapted model to bring care closer to communities was observed. In this model, advanced health posts staffed by nurses and matrons offered care for all age groups and pathologies, diverging from traditional CHW-led iCCM. In EGPAA, mobile teams tailored to pastoralist populations used real-time migration data to determine service points. These models demonstrate MSF's strengths to adapt new models of community care as well as tailored approaches to iCCM as needed per the context. To ensure quality and consistency of care, these differentiated approaches would benefit from a harmonized strategic framework, consistent operational norms, and shared learning.

Variations in CHW selection, training, and supervision point to the need for a set of MSF-OCB iCCM HR, training, and supervision manuals and adaptable tools which can be used more consistently across project sites. While some sites implemented MOH-aligned criteria and co-developed selection processes with communities, others relied on more informal or ad hoc models, leading to inequitable CHW coverage. Similarly, differences in training duration, refresher schedules, and access to literacy-adapted tools impacted the quality and confidence of service delivery. Planning and budgeting processes also varied. In Yei, for example, iCCM activities benefited from detailed operational plans, while other projects struggled with unclear iCCM scale-up pathways, weak cost forecasting, and inconsistent CHW incentive models. The available WHO training manual (138 pages) was noted to be too complex for practical use. The absence of an MSF iCCM training manual or supervision checklists was noted to reduce the ability to systematically train and track CHW performance. Additionally, in some locations, training and supervision are highly intensive. e.g., requiring several days/weeks of in-person training and supervision by MSF staff for one CHW, which limits scalability. In other cases, refresher training and supervision were informal or irregular.

These gaps reflect a broader need for dedicated iCCM planning tools and early integration of scalability and sustainability strategies. As noted above, where iCCM is determined to be a priority approach, MSF-

OCB can incorporate clear objectives for iCCM's role within the Medical strategy and develop a formal MSF-OCB iCCM strategic framework that outlines standardized care packages, technical quality norms, and operational standards as well as a set of adaptable MSF-OCB iCCM technical and operational tools. Following the experience of MSF-OCBA, and with sufficient human resources in place to develop them, these tools could be compiled into a shared online toolkit accessible to all MSF-OCB, project, and iCCM staff—with selected components shared with MOHs and implementing partners.

EQ3: Successes, Challenges, and Lessons Learned

MSF-OCB iCCM interventions have expanded access to care - as demonstrated in the increase in new consultations, with the largest share of the increase in children 12-59 months, in project sites with iCCM activities from 2022-2024 (Annex 11, Graphs 11.1 and 11.2, 11.3, and 11.4). Community trust in CHWs is consistently high, with CHWs valued for their proximity, cultural competence, and ability to provide first-line care. In Kenema, Yei, and EGPAA, for example, structured training, supportive supervision, and strong community relationships were key enablers of effective care interventions. However, persistent challenges were observed. The scale of iCCM activities in MSF-OCB remains relatively modest with projects managing between 2 to 115 iCCM activity sites, according to the document review and KIIs. The evaluation team did not observe an MSF-OCB indicator or target for expansion of the number of sites or number of consultations per year. In Masisi, the project team had discussed the wish to expand to two new sites per year, however during the review process for this report it was noted that those projects are on hold due to security concerns.

Referral systems within existing iCCM activities remain a challenge, with barriers such as long distances, insecurity, stigma, and financial constraints undermining continuity of care. Only 20–50% of referrals were completed in some sites, and documentation of referral outcomes was inconsistent. In Tombouctou and Niono, caregivers often refused referrals due to fear of long travel times or associated costs.

Supply chain reliability and storage of medications also varied. In Masisi and Kebbi, close coordination between MSF and MOH ensured timely resupply and accurate consumption tracking. In contrast, sites like Cibitoke and Tombouctou experienced recurrent stockouts, delayed restocking, and limited access to weatherproof storage—raising concerns about the stability of medicine availability. In most sites, CHWs transported and stored medications in backpacks or plastic market bags, with some using community-owned storage managed by supervisors or local chiefs.

Supervision was another area of uneven implementation. Sites like Yei and Kenema used structured supervision protocols—including checklists and performance reviews—to support CHW quality and motivation. Other sites lacked regular follow-up, especially in insecure or hard-to-reach areas, leading to missed opportunities for skills reinforcement and data quality monitoring.

Despite these constraints, MSF and MOH staff, community leaders, and CHWs demonstrated remarkable dedication. Many CHWs balanced their health roles with farming or caregiving responsibilities, often with little formal compensation. Peer support, community recognition, and access to basic supplies were cited as motivating factors, but inconsistent incentive schemes—ranging from livestock gifts to unpaid volunteerism—posed significant retention risks.

EQ4: Strategic Recommendations for Enhancing Effectiveness and Reach

To address implementation challenges and scale effective models, alongside the MSF-OCB iCCM strategic framework, the proposed toolkit with adaptable technical and operational tools can be aligned to MOH guidance in each country. The strategy and toolkit should provide clear guidance on service packages, diagnostic tools, training approaches, supervision structures, and referral protocols, while allowing for flexibility in fragile and rapidly changing contexts. **Key elements of the strategy and toolkit to enhance effectiveness and reach may include:**

- **Improving the quality of community case management** by:
    - Reinforcing financial planning, feasibility assessment, and transition planning.
    - Developing a health promotion and community engagement framework and adaptable literacy-sensitive training curricula and visual job aids.
    - Ensuring CHWs have access to essential tools such as respiratory timers and MUAC tapes as well as case management algorithms, diagnostic tools, training manuals, and supervision checklists tailored to MOH guidelines and local contexts.
    - Providing regular refresher training and supportive supervision tailored to CHW capacity, supported by standardized training and supervision tools, adaptable to align with MOH frameworks, to reinforce CHW capacity, e.g., checklists, scorecards, mentorship, and mobile strategies (e.g., phone, WhatsApp).
    - Scaling peer learning and mentorship models from sites with these activities, such as Masisi and EGPAA.

- **Strengthening referral systems** by:
    - Expanding access to transport solutions, such as community-managed emergency transport funds or motorbike voucher schemes.
    - Piloting mobile or digital referral tracking tools to monitor completion and close the referral loop.
    - Standardizing referral and counter-referral forms across sites.
    - Training CHWs to effectively counsel caregivers and follow up on referrals.

- **Promoting local data use for decision-making** by:
    - Introducing simplified dashboards and visual tools to support data interpretation at the community level.
    - Strengthening routine monitoring and aligning indicator definitions across sites to improve planning.
    - Reinforcing data completeness, consistency, and quality including the consistent tracking of key indicators across registers and data summaries; supervision to reconcile patient registers with medicine consumption logs, and CHW data literacy.

- Institutionalizing participatory data review meetings with CHWs and community leaders.
- Scaling grassroots innovations such as laminated quick-reference tools and CHW-developed visual summaries.

- **Advancing equity and inclusion in service delivery** by:
  - Conducting regular, disaggregated needs assessments to identify gaps in coverage.
  - Adapting services and communication strategies based on population movement, marginalization, or seasonal access barriers.

These efforts will be essential to improving both the quality and equity of iCCM interventions across MSF-OCB's diverse operational contexts.

EQ5: Alignment with National Health Strategies and Pathways for Scale-Up

Sites that engaged MOH counterparts from the outset—such as Yei (South Sudan) and Kenema (Sierra Leone)—demonstrated stronger prospects for long-term continuity. Joint supervision, shared tools, and integration into health information systems helped ensure government ownership and transition readiness.

Conversely, in contexts like Tombouctou and Niono, the absence of clear MOH collaboration or transition planning raises questions about long-term service viability. Without formal MOH recognition of CHWs or integration of iCCM commodities into national procurement systems, MSF-supported services risk collapse when projects end.

To address this, MSF should institutionalize co-developed transition planning from project inception. Dedicated MOUs, integration of iCCM costs into MOH budgets, and formalization of CHW roles within national HR structures are all essential steps. However, the absence or delay of such transition plans should not prevent the implementation of iCCM or iCCM-like community care in contexts where there is a medical-humanitarian need for closer-to-home care due to disruption or difficulty in accessing timely primary healthcare. In some cases, this disruption may be temporary and could also serve as a rationale for MSF's eventual exit. MSF should also intensify its engagement with global actors—such as UNICEF and the Global Fund—to promote co-financing mechanisms and policy harmonization.

Conclusion and Next Steps

MSF's community-based service delivery model has increased health seeking and health care use, as measured by new consultations (Annex 11, Graphs 11.1,11.2, 11.3, and 11.4) in fragile and hard-to-reach MSF-OCB project settings. To maintain and expand this impact, MSF-OCB will need to clarify institutional priorities and support their achievement. To operationalize these recommendations, alongside the list of Next Steps presented in the Executive Summary, the evaluation team proposes **seven strategic actions**:

1. **Determine the level of prioritization MSF-OCB places on iCCM activities within the continuum of quality person-centred care provided by project teams.** As iCCM is determined to be a priority

approach based on medical humanitarian needs of the most vulnerable and marginalized group, gaps in services, and access barriers, MSF-OCB can build on its current updates to its strategy to incorporate clear objectives for iCCM's role within the strategy.

2. **Identify MSF-OCB resources needed to proceed with developing an MSF-OCB iCCM Strategic Framework, including a landscape of key challenges, standard care packages, and a technical and operational toolkit.** Based on experience in other centres (eg MSF-OCBA), which MSF-OCB could take advantage of, the roadmap and toolkit would require dedicated resources (approximately two years with dedicated senior staff time to design and develop the toolkit) and may include harmonized guidance and adaptable tools to support consistent implementation of each benchmark area across sites. For example, MSF-OCB guidance and tools for:
    a. Financial planning, feasibility assessment, and transition
    b. Assessment, site selection, resource planning, and co-design of the intervention with community participation
    c. Case management algorithms, diagnostic tools, training manuals, and supervision checklists tailored to MOH guidelines and local contexts
    d. Standardized training and supervision tools, adaptable to align with MOH frameworks, to reinforce CHW capacity, e.g., checklists, scorecards, mentorship, and mobile strategies (e.g., phone, WhatsApp)
    e. A health promotion and community engagement framework and adaptable literacy accessible tools and inclusive strategies, including digital tools, local media, and community-led initiatives to reinforce messages and reach vulnerable groups
    f. Transportation support, standardized referral/counter-referral forms, and real-time tracking or mobile monitoring mechanisms
3. **Pilot, document and Scale Adaptable Tools and Innovations included in the toolkit with MSF-OCB project teams** across the eight benchmarks. This may include dedicated sessions during ARO meetings, webinars, training, and/or e-learning for project staff to share the strategic framework, seek inputs and buy-in for the strategy, and to facilitate ongoing training and refreshers to reinforce a common understanding of the strategy and harmonized understanding and use of the information and tools. It will be important to maintain an ongoing commitment to and plan for technical updates to continue to strengthen and refine the toolkit.
4. **Continue MOH Engagement and Transition Planning:** Continue to reinforce MOH involvement in existing and new iCCM sites, with shared supervision, training, and commodity planning from day one.
5. **Reinforce the quality of iCCM service delivery**, through strengthened training, supervision, mentoring, and close monitoring of case management and referral data to guide ongoing continuous improvement.
6. **Improve Data Feedback and Community Ownership:** Roll out user-friendly data tools and participatory planning forums that empower CHWs and communities to drive service improvement.

Strengthen routine monitoring and alignment of indicator definitions across sites to improve planning. Reinforce data completeness, consistency, and quality including the consistent tracking of key indicators across registers and data summaries; supervision to reconcile patient registers with medicine consumption logs, and CHW data literacy.

7. **Reinforce iCCM supply chain and storage guidance and tools** for PMRs to support project teams to:
    a. Maintain continuous supply of essential medicines and diagnostic tools for iCCM, and tailored resupply strategies for remote or hard-to-reach areas, reducing travel requirements for CHWs
    b. Reinforce communication between MSF, MOH, and CHWs, including joint planning and quantification for supplies needed; clarity of supply channels for stocks stored at health facility level; low-stock warning and new supply requisition systems; quality storage, drug safety, and medical waste management training and safeguards

By embedding these priorities into future iCCM programming, MSF can continue and scale further access to effective, responsive, and impactful patient-centred care—while positioning itself as a leader in the global movement for equitable community health.

ANNEXES

ANNEX 1: EVALUATION QUESTIONS FROM THE ORIGINAL TOR FOR THE THEMATIC EVALUATION OF ICCM ACTIVITIES IN MSF-OCB SETTINGS

1) Describe the current MSF-OCB iCCM portfolio (e.g. types of sites, package, modalities of HR management and supervision).
2) Explore rationale behind site selection as well as deviations from standard package if any, and reasons behind.
3) Assess the portfolio's overall value, its trends and patterns, highlighting challenges and bottlenecks, good practices and successes.
4) Identify strategic recommendations for enhancing and implementing iCCM activities in existing and future OCB projects

ANNEX 2: EVALUATION MATRIX

Our evaluation matrix is designed to comprehensively assess the iCCM interventions in the MSF-OCB portfolio against the WHO iCCM benchmarks using the RE-AIM framework. The RE-AIM framework evaluates interventions through five dimensions: Reach, Effectiveness, Adoption, Implementation, and Maintenance. By aligning these dimensions with the programmatic areas, we can systematically evaluate each project's performance, identify areas of strength, and pinpoint opportunities for improvement. This structured approach ensures a thorough and multidimensional assessment, facilitating actionable insights and robust recommendations for enhancing the iCCM initiatives.

The evaluation matrix was developed in alignment with results of comprehensive document review and inputs from project teams, CG members, and other MSF Leadership.

REACH				
Programmatic Area	**Question**	**Judgment Criteria**	**Indicator**	**Data Sources**
Human Resources	How many CHWs are currently available for a given project? Is this number adequate to reach the target population? Which staff resources are available to provide training, supervision, and reporting support for iCCM implementation and quality improvement? What are the demographic and professional backgrounds of the CHWs? What is the gender balance among CHWs? What are the age differences, and the age ranges across CHWs? Is there sufficient training to provide the given set of services to the target population?	Number and diversity of CHWs to reach the target population	Number of CHWs per population served Geographic distribution of CHWs	HR record Project reports DHIS2 records Stakeholder interviews (project managers, health facility staff)
Supply Chain Management	Are essential iCCM supplies and health commodities reaching all target areas and populations as planned? What barriers exist to the distribution of iCCM supplies in hard-to-reach areas?	Days without stock-out of iCCM supplies, such as appropriate 'child-friendly' medicines, to all target areas	Evidence on the target areas receiving adequate iCCM supplies Geographic distribution of supply deliveries	Inventory records Stakeholder interviews (project managers)
Service Delivery and Referral	What are the geographic, demographic, and contextual specifics of each project site, and how do these factors influence the delivery and effectiveness of iCCM services?	Reach of iCCM services to the priority populations	Proportion of the target population using iCCM services Geographic distribution of service delivery points	Service delivery records Stakeholder interviews (health facility staff, CHWs)

	What proportion of the target population is receiving iCCM services? Are there specific groups or regions within the target population that are underserved?			
Communication and Social Mobilization	How well do communication and social mobilization efforts reach the target population? Are specific groups within the target population being effectively engaged?	Reach of communication and social mobilization efforts to priority populations	Number and types of communication channels used (e.g., radio, posters, community meetings)	Communication campaign reports. Stakeholder interviews (community members, beneficiaries)
Monitoring and Evaluation and Health Systems	Are M&E and HIS systems covering all geographic regions and populations targeted by the iCCM project as intended? Are data collection tools and methods accessible to all CHWs and health facilities?	Reach of M&E and HIS to all targeted regions and populations	Evidence on the coverage of regions and populations by M&E and HIS activities Accessibility of data collection tools and methods to all CHWs and health facilities Percentage of CHWs and facilities submitting regular reports	System access logs Submission records report Stakeholder interviews (CHWs)

EFFECTIVENESS				
Programmatic Area	**Question**	**Judgment Criteria**	**Indicator**	**Data Sources**
Coordination and Policy Making	To what extent does coordination take place? What were reasons for achievement or non-achievement of the coordination? How do the iCCM activities align with and support MSF's broader health goals and strategic objectives in the countries where they are implemented?	Extent to which the activities have achieved the project objectives to date	Evidence demonstrating outputs / results of the project to date are contributing to / in line with the project objectives Stakeholders' perceptions of the results achieved or not achieved so far	Project reports, other relevant reports Stakeholder interviews (PMRs)
Costing and Financing	Are the financial resources adequately planned and allocated to achieve the project's objectives?	Efficient allocation of financial resources	Proportion of budget allocated to key components (e.g., training, supplies)	Budget plans, expenditure reports Stakeholder interviews (project managers
Human Resources	How effective are the CHWs in delivering iCCM services? Which project approaches are in place to build CHW capacity? How do CHWs perceive their role and effectiveness in the context of the iCCM intervention?	Competence and effectiveness in CHW service delivery Satisfaction and perception of the CHW from project team	Completion rate of iCCM training programmes Feedback from community members on CHW performance Evidence on the satisfaction and perception of CHW	CHW training records Stakeholder interviews (community members, project managers, CHWs)
Supply Chain Management	How effective is the supply chain in ensuring timely delivery of high-quality iCCM health commodities and supplies? What impact do supply chain	Delivery of iCCM supplies	Evidence on delivery time for iCCM supplies Frequency of stock-outs and their duration	Inventory records Stakeholder interviews (project managers)

	issues have on the quality and scalability of iCCM services?			
Service Delivery and Referral	Which health areas are targeted by the iCCM interventions, and are there additional health services requested by the community? How does iCCM respond to these requests? How effective are the iCCM services in improving health outcomes? How are referrals made and how is care for complicated illness ensured through the iCCM system?	Effectiveness of iCCM services and appropriate, timely referrals	Health outcomes achieved through iCCM (e.g., reduction in child mortality) Percentage of referrals that are successfully followed up and completed Evidence on the satisfaction of the beneficiaries	Health data, referral logs, follow-up reports Stakeholder interviews (health facility staff, beneficiaries)
Communication and Social Mobilization	How effective are the communication and social mobilization strategies in increasing awareness and changing behaviours related to iCCM?	Effectiveness of communication and social mobilization strategies in reaching iCCM priority groups	Changes in health-seeking behaviours and service use Health outcomes related to the uptake of iCCM services (e.g., reduction in child mortality, increased treatment rates)	Health outcome data, service use records (DHIS2) Stakeholder interviews (community members, beneficiaries)
Supervision and Performance quality improvement	How effective are supervision and quality improvement activities in improving CHW performance and service quality? What impact do supervision and quality improvement activities have on health outcomes?	Effectiveness of supervision and quality improvement in improving iCCM performance and service quality	Changes in CHW performance metrics (e.g., adherence to protocols, service delivery quality) Feedback from CHWs and beneficiaries on the quality of supervision	Supervision logs CHW records Stakeholder interviews (CHWs, health personnel, beneficiaries)
Monitoring and Evaluation and Health Systems	How effective are M&E and HIS in tracking and reporting iCCM project outcomes? How timely and accurate is the data collected through M&E and HIS systems?	Effectiveness of M&E and HIS in tracking and reporting accurate data Effectiveness of	Timeliness of data submission and reporting Accuracy and completeness of data collected	Data submission logs Project reports Health outcome data

		M&E and HIS in tracking and, reporting timely data	Use of data for decision-making and project improvement	Stakeholder interviews (M&E advisor, project manager)

ADOPTION				
Programmatic Area	**Question**	**Judgment Criteria**	**Indicator**	
Coordination and Policy Making	To what extent have the policies relating to the iCCM activities been adopted by the MOH, providers, CHWs, and communities? What factors facilitate or hinder the adoption of iCCM policies by the MOH, providers, CHWs, and communities? How are iCCM activities designed and decided upon, including the selection of intervention packages and priority groups? What is the role of community involvement in these decision-making processes?	Adaptation and integration Community Acceptance and Use Challenges and barriers	Extent to which iCCM protocols have been integrated into existing health systems and adapted to local contexts Identification of challenges and barriers to adoption and strategies used to overcome them	Implementation reports, policy documents Stakeholder interviews (CHWs, healthcare providers, and community leaders)
Service Delivery and Referral	To what extent have health workers and community members adopted iCCM service delivery and referral practices as intended? What factors influence the adoption of iCCM service delivery and referral protocols?	Adoption of iCCM service delivery and referral practices	Number of health workers trained in iCCM service delivery and referral protocols Barriers and facilitators to adoption identified by health workers and community members	Training records Stakeholder interviews (CHWs, community leaders, community members)
Communication and Social	To what extent have community leaders, health workers, and the general population adopted the	Adoption of iCCM messages and practices among	Number of community leaders and health workers actively	Stakeholder interviews (community

Mobilization	messages and practices promoted through iCCM communication and social mobilization efforts? Which factors influence the adoption of these messages and practices?	key stakeholders	promoting iCCM messages Barriers and facilitators to adoption identified by community members and stakeholders	leaders, community members, CHWs)

IMPLEMENTATION				
Programmatic Area	**Question**	**Judgment Criteria**	**Indicator**	
Coordination and Policy Making	To what extent do existing MSF-OCB iCCM interventions implement iCCM at the community level as intended, in alignment with the standardized iCCM guidelines and national policies and guidelines? Which factors facilitate or hinder the implementation of the iCCM intervention in alignment with following the standardized iCCM guidelines and national policies and guidelines from the coordination to the community level? How are needs assessments and situational analyses conducted to inform iCCM implementation, and what key components do these assessments include? How has the global iCCM model been adapted in various project sites to meet local health needs and conditions, and what are the underlying reasons for these adaptations?	Adherence to iCCM standardized and national guidelines	Extent to which the intervention is being implemented as intended, following the standardized and national iCCM guidelines.	Stakeholder interviews (CHWs, supervisors, community members)

	What are the roles and contributions of external donors, normative bodies, technical advisors, and implementing partners in supporting iCCM interventions, and how do these roles impact project activity implementation?			
Costing and Financing	In the implementation process, how is the budget decided, how are resource needs quantified and how is it allocated/ distributed for each project? (EQ1) Which factors influence the decision to fund the iCCM activities in general and the resources needed to effectively implement iCCM?	The extent to which the activity budgeting process meets iCCM standards	Evidence on the budget allocation process Perceptions of the iCCM funding and allocation process	Budget plans, expenditure reports Stakeholder interviews (donors, project managers)
Human Resources	What training support and supervision mechanisms are in place for CHWs? What support structures and mechanisms are provided by the MOH, health facilities, and community organisations for CHWs, and how are these structures designed to enhance the effectiveness and integration of CHWs in iCCM activities? Are there clearly defined TOR for CHWs that outline their roles and responsibilities within the project, and how do these roles align with the project's goals and strategies?	Implementation of iCCM protocols	Support mechanisms (e.g., refresher training, supervision)	Supervision reports, observation checklists Stakeholder interviews (CHWs)
Supply Chain Management	To what extent have the project sites adopted MSF iCCM supply chain protocols as intended? What factors influence the adoption of supply chain management practices for	Adoption of iCCM supply chain protocols	Number of health facilities and CHWs trained in supply chain protocols Barriers and facilitators to the adoption of supply	Training records Stakeholder interviews (health facility staff,

	iCCM?		chain protocols	CHWs)
Service Delivery and Referral	How consistently and faithfully are iCCM service delivery and referral protocols implemented? Which support and supervision approaches are in place for iCCM service delivery and referrals? What are the core components of the iCCM activities across different settings, and what justifications are provided for the selection of these components? What guidelines and protocols are established for clinical assessment, diagnosis, management, and referral in iCCM activities, and how do these guidelines ensure the rational use of medicines and effective referral systems?	Implementation of iCCM service delivery and referral guidelines	Adherence to service delivery and referral guidelines by health workers Availability of resources and tools for implementing service delivery and referrals	Implementation reports Stakeholder interviews (project managers)
Communication and Social Mobilization	How consistently and effectively are communication and social mobilization strategies implemented?	Implementation of communication and social mobilization strategies	Availability of resources and tools for implementing communication and social mobilization strategies	Implementation reports, supervision logs Stakeholder interviews (project managers, health facility staff)

MAINTENANCE				
Programmatic Area	**Question**	**Judgment Criteria**	**Indicator**	
Coordination and Policy Making	Which approaches have been implemented to support the sustainability of iCCM intervention outcomes?	Sustainability and Long-Term Commitment	Evidence of long-term commitment to iCCM from MOH and local authorities and sustainability of funding and resources	Policy statements, funding reports Stakeholder interviews (health officials, PMRs)
Costing and Financing	Which approaches have been set up to ensure the sustainability and scalability of the project? How does the project ensure the financial sustainability of its interventions?	Diversity of funding sources	Evidence of long-term commitment to iCCM from local health authorities and sustainability of funding and resources Level of financial commitment from local and national governments	Policy statements, funding reports Stakeholder interviews (health officials from local and national levels, project managers)
Human Resources	Which strategies are in place to retain CHWs and maintain their motivation?	Sustainable engagement and performance of CHWs	CHW satisfaction and motivation levels	Reports, training logs, Stakeholder interviews (CHWs)
Supply Chain Management	How sustainable are the supply chain practices for iCCM in the long term? Which strategies are in place to ensure the continued availability and quality of iCCM supplies?	Sustainable supply chain practices for iCCM	Long-term funding and resource plans for the supply chain Strategies for mitigating risks and addressing supply chain disruptions	Strategic plans, budget reports Stakeholder interviews (supply chain

				managers, project managers)
Service Delivery and Referral	How sustainable are the iCCM service delivery and referral practices in the long term? What strategies are in place to ensure the continued quality and availability of iCCM services and referrals?	Sustainable iCCM service delivery and referral practices Quality iCCM service delivery and referral practices	Long-term funding and resource plans for iCCM service delivery and referrals Strategies for continuous quality improvement and addressing service delivery and referral challenges	Strategic plans Funding reports Stakeholder interviews (project managers, PMRs)
Communication and Social Mobilization	How sustainable are the communication and social mobilization efforts for iCCM in the long term?	Sustainable communication and social mobilization efforts Effective communication and social mobilization efforts	Long-term plans and funding for communication and social mobilization activities	Strategic plans, funding reports Stakeholder interviews (project managers, funding manager)
Supervision and Performance quality improvement	How sustainable are the supervision and quality improvement practices for iCCM in the long term? What strategies are in place to ensure the continued quality and effectiveness of supervision and performance assurance?	Sustainable supervision and quality improvement practices Effective supervision and quality improvement practices	Long-term plans and funding for supervision and quality improvement activities Strategies for continuous improvement and addressing challenges in supervision and quality improvement	Strategic plans Funding reports Stakeholder interviews (project managers, funding manager)
Monitoring and Evaluation and Health Systems	How sustainable are the M&E and HIS practices for iCCM in the long term? Which strategies are in place to ensure the continued quality and effectiveness of M&E and	Sustainable M&E and HIS practices Effective M&E and HIS practices	Long-term plans and funding for M&E and HIS activities. Strategies for continuous improvement and addressing challenges in	Strategic plans Funding reports Stakeholder interviews

	HIS activities?		M&E and HIS	(project managers, funding manager)

ANNEX 3: FULL PROJECT SITE DESCRIPTIONS OF ICCM INTERVENTIONS AS PER FEBRUARY 2025

	Key Information					
Project Site	**Project start date**	**Start date of iCCM activities**	**Number of iCCM sites (villages) per project**	**Age range covered in project**	**Estimated target population covered by iCCM**	**National guidelines for iCCM available (Y/N)**
Cibitoke (Burundi)	janv-24	2024	12	Focus: Children <5	43:815 children <5	Y
EGPAA (South Sudan)	April 2022			Focus: Children <5 Additional: Malaria diagnosis and treatment for all ages	200,000 people (focus on semi-nomadic populations living in remote villages)	Y
Kebbi (Nigeria)	March 2022	April 2023	4 LGAs (Maiyama, Bagudo, Jega, Koko); 23 wards (To confirm) and 115 settlements	Focus: Children ages 6-59 months	The target population of the nutrition and ICCM component of the project is children aged 6 – 59 months (Under 5's) at particular risk for malnutrition and common childhood diseases. There is a total of 230,869 children between 6-59months-old in the 4 LGA based on projection from the Nigeria population census.	Y
Kenema (Sierra Leone)	2018	Feb 2022	9 PHUs	Focus: Children <5		Y

Masisi (DRC)	2007	March 2022	2 sites: 1) Kibugu/Bushenge Village, Muheto Health Area and 2) Kashunga Village, Ngomashi Health Area	Focus: Children <5 Additional: Malaria diagnosis and treatment for all ages		Y
Niono (Mali)	2020	August 2020	22	Focus: Children <15 Additional: Pregnant women; people who suffered a trauma	276059	Y
Tombouctou (Mali)	2021	Feb 2022	14	Focus: Children <15 Additional: Pregnant women; elderly; other vulnerable groups	20000	Y
Yei (South Sudan)	2016	2022 (April)		Focus: Children <5	~630,000 people (focus on conflict-affected and semi-nomadic communities)	Y

	Program Components	
Project Site	**Core iCCM activities**	**Additional related project activities**
Cibitoke (Burundi)	1) Malaria diagnosis and treatment 2) Health promotion	1) Malnutrition screening and referral (planned) 2) Vaccination status assessment (malaria vaccination for children at 6 months; routine immunisation catch-up)
EGPAA (South Sudan)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) GBV services
Kebbi (Nigeria)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) Malnutrition screening and referral 2) Environmental health improvement 3) Free nutrition activities for priority populations
Kenema (Sierra Leone)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) Malnutrition screening and referral 2) Vaccination status assessment 3) Referral linkages to PHUs and Kenema Government Hospital
Masisi (DRC)	1) Malaria diagnosis and treatment 2) Diarrhea diagnosis and treatment 3) Recognition and referral of danger signs 4) Health promotion	1) Malnutrition screening and referral 2) Vaccination status assessment 3) Referral for cases of SV and GBV 4) Mental health services

Niono (Mali)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) Malnutrition screening and referral 2) Vaccination status assessment 3) Postpartum home visits 4) Mental health services
Tombouctou (Mali)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) Malnutrition screening and referral 2) Vaccination status assessment 3) Health post services for other diseases 4) Mental health services 5) Nutrition screening 6) GBV services
Yei (South Sudan)	1) Malaria diagnosis and treatment 2) Pneumonia diagnosis and treatment 3) Diarrhea diagnosis and treatment 4) Recognition and referral of danger signs 5) Health promotion	1) Malnutrition screening and referral 2) Vaccination status assessment 3) Screening and referral for SAM and nutritional danger signs

	Information on HCWs and Referrals Process				
Project Site	**Number of HCWs**	**Demographics (Gender, Education, etc)/ Selection criteria**	**Estimated number of households covered by HCW**	**Type of incentives/ retention strategies (mentorship, psychosocial support, etc)**	**Description of referrals process**
Cibitoke (Burundi)	63	Higher female (75%); less educated (secondary education; meduim education (First cycle secondary school); Selected by the government	Geographic coverage: Radius around the healthcare facility, starting at 5 km	1)Mentorship/supervision 2) Financial support (Fixed amount per month)	CHWs refer children with danger signs to the regional health facility
EGPAA (South Sudan)		Higher female-male ratio due to nomadic populations; Selected by community; focused on caregivers		1) Mentorship/ supervision/ support from health facility staff 2) Recognition from community 3) Access to continual resource and training 4) Government salaries (confirmed)	
Kebbi (Nigeria)	115 CORPs (5 per ward)	~15% of CORPs are female	Total estimated population of the 4 LGAs with iCCM activities is 1.3 million. Estimated average size of household in Kebbi is 5.5 (Source: https://opendataforafrica.org/atlas/Nigeria/Kebbi/Household-Size) Estimated number of HHs: 236,363	MSF establishes an MOU with MOH, with 3 key considerations: 1) For the CORPs who have contracts with the MOH, MSF follows the MOH guidelines and pays based on hours worked. If the CORPs works 208 hours per month, they are paid full compensation; otherwise, compensation is prorated based on the number of hours worked. 2) For CORPs who do not have MOH contracts, they are considered as volunteers by the MOH. In this case, MSF and	If there are any danger signs, the CORPs will identify and quickly refer to hospital. Will also do MUAC and refer to ATFC. Community leader noted that he encourages community members to follow-up on the referrals. Considerations: - Distance is an issue for referrals and

				LGAs pay stipends 3) CORPS may work with other agencies/initiatives as well	then even if caregivers go to facilities, they may not find staff or competent staff - Last year, MSF-Kebbi wanted to train focal people in referral facilities and/or to strengthen referrals to MSF facilities, but the training was not possible.
Kenema (Sierra Leone)				1) Stipends 2) Regular supervision	CHWs refer children with danger signs to the nearest health facility
Masisi (DRC)	2 CHWs	**CHW and site selection criteria:** 1. Chosen by the community on a voluntary basis. 2. Must be literate. 3. Distance from the health centre is > 5 km, with access difficulties (e.g., hills, rivers/streams, bridges in poor condition). 4. Population > 100 households	~50 households per CHW -2 CHWs currently -100 households	- $15 per month - Income-generating activity: depending on their preference, receive a goat, sheep, or pig once a year to produce income worth $40 for its income.	CHWs recognize signs of serious illness Referral to the nearest health centre, health post, reference health centre
Niono (Mali)	14	The RECOs were identified according to a quota set by MSF: 273 relays for the five health areas and 22 CHWs. CHWs are recruited based on their educational	Geographic coverage: 15 km radius/CHW and hard-to-reach population	1)Mentorship/supervision 2) Financial support (Fixed amount per month)	CHWs recognize signs of serious illness Referral to the nearest health center (CSCOM) or District Hospital depending on

		qualifications, then trained by the state to become nursing assistants, and placed in communities.			the severity of the signs
Tombouctou (Mali)	22	The RECOs were identified according to a quota set by MSF: 273 relays for the five health areas and 22 CHWs. CHWs are recruited based on their educational qualifications, then trained by the state to become nursing assistants, and placed in communities.	Geographic coverage: 15 km radius/CHW and hard-to-reach population	1)Mentorship/supervision 2) Financial support (Fixed amount per month)	CHWs recognize signs of serious illness Referral to the nearest health center (CSCOM) or District Hospital, depending on the severity of the signs
Yei (South Sudan)	107 HCWs	BHWs selected by community; mostly with secondary education; includes both men and women; Criteria is 25-45 years old	Coverage depends on number of households in a village; BHW responsible for ~40 households in the area	1) Through providing goods (such as backpacks) to improve ways of working 2) Through continual training, with a focus on appreciation for HCWs 3) Through motivation that they will eventually be absorbed by the MOH (No financial incentives mentioned) All BHWs receive a monthly financial incentive of $50 and $100 for supervisors	BHWs trained to identify danger signs and refer patients to health facilities

	Information on Supervision		
Project Site	**Number of iCCM supervisors**	**Mode of supervision (On-site, remote, etc)**	**Description of supervision process**
Cibitoke (Burundi)	Not available	On-site: Weekly supervision. Each CHW is supervised once per month	There is a routine supervision planning
EGPAA (South Sudan)		On-site: supervisors make plans for daily field visits; can be limited due to insecurity and remoteness	Supervisor plans routes in advance due to logistical challenges
Kebbi (Nigeria)	1 CORPs peer supervisor per 5 CORPs	On-site	MOH and MSF conduct both joint and individual on-site supervisions; report use of a supervisory checklist
Kenema (Sierra Leone)		On-site/ monthly supervision	CHWs receive one-on-one follow up on a monthly basis from supervisors
Masisi (DRC)		On site and at health centre	Following training: MSF provides intensive supervision for 2 months (for 3-4 days per week if the context allows, including sleeping at the nearest health centre) Joint MSF/MOH Health Zone Implementation Steps-Monthly Joint Supervision (Weekly according to KIIs): Nurse/HP - MSF & Health Zone (Health zone supervisor or health centre head nurse supported) Reportedly use a supervision checklist with 10 indicators. The team will travel by motorcycle or on foot, depending on rainfall.
Niono (Mali)	3	Remote for security reasons	Before the security situation became a concern, the DTC and MSF teams jointly supervised, conducting monthly assessments based on a supervision and quality assessment grid. Currently, this supervision stops at the CSCOM level.
Tombouctou (Mali)	3	Remote for security reasons	Before the security situation became a concern, the DTC and MSF teams jointly supervised, conducting monthly

			assessments based on a supervision and quality assessment grid. Currently, this supervision stops at the CSCOM level.
Yei (South Sudan)	BHI Supervisor responsible for no more than 15 BHWs	On-site (when possible); monthly (may also be weekly, depending on accessibility and need for targeted supervision)	BHWs submit monthly service delivery data (consultations, treatments, referrals) to BHW supervisors; these in turn review the data and present to the BHI Supervisors who review the data gain, compile and forward it to the MSF data supervisor for submission to the MOH

ICCM INTERVENTIONS IN CIBITOKE, BURUNDI

a) Overview and Objectives: The iCCM interventions aim to contribute to the reduction of malaria-related morbidity and mortality in the Cibitoke Health District among children under five. It was initially called the 'Malaria Project' due to the predominance of malaria-related activities. However, as the country has a strategy known as 'PECADOM', which involves treating malaria cases at home, the project has expanded to include the detection and treatment of other childhood diseases, such as diarrhoea and coughs/fast breathing, as well as malnutrition screening, all at the community level. Consequently, some interventions, such as malaria vaccination, are carried out in health facilities, while others are managed at the community level. The primary objectives include ensuring that children under five have access to a comprehensive package of malaria prevention and integrated case management services, as well as increasing community awareness of disease prevention measures.

b) Populations served: Children under the age of 5 are the priority population for integrated disease management at the community level in the Cibitoke Health District.

c) Intervention Areas and Package of Services:

- **Prevention:** Malaria vaccination (for children at six months), routine immunisation catch-up, distribution of long-lasting insecticide-treated nets (ITN) and malnutrition screening, health promotion, and awareness campaigns and perennial malaria chemoprevention.
- **Curative Services:** Early quality malaria case management at the community level through iCCM, and ambulance referral for severe cases, diarrhoea, cough/fast breathing and case management for severe malaria and comorbidities at hospital level (pediatric ward).

d) Key Benchmarks Addressed:

- **Coordination & Policy:** Collaboration with the MOH, UNICEF, WHO, USAID, and other health partners.
- **Human Resources:** Training and supervision of community health workers and healthcare providers in malaria prevention and treatment.

- **Service Delivery & Referral:** Strengthening referral pathways for severe malaria cases and ensuring free treatment at district health facilities.
- **Supply Chain Management:** Ensuring the availability of malaria vaccines, rapid diagnostic tests, and antimalarials across supported sites.
- **Monitoring and Evaluation and Health Information Systems:** The project is specifically called the 'malaria project' and, as it began in 2024, the data available in the DHIS2 system is only aggregated over the single year of the project. The logical framework provided to the evaluation team does not present indicators specific to the iCCM; however, medical data is collected on malaria (test and treatment), diarrhoea, cough/rapid breathing, immunisation, referral and malnutrition. Referral data issued in communities are available, but those received in health facilities are not tracked at all.

e) Achievements

- Strengthened community engagement through educational campaigns, school-based malaria prevention initiatives, and mass mobilization events.
- Improved malaria case management at both community and facility levels, with early detection and timely referrals for severe cases.

f) Challenges:

- Limited community adherence to malaria prevention strategies, requiring continuous health education.
- Seasonal variations in malaria incidence, including malaria outbreaks in Burundi, creating spikes in demand for services.
- Supply chain issues in ensuring the consistent availability of malaria vaccines and chemoprophylaxis drugs.
- Fuel shortages.

g) Looking Ahead: The project aims to enhance community-driven health and strengthen data collection systems for improved monitoring of intervention outcomes.

ICCM INTERVENTIONS IN EGPAA, SOUTH SUDAN

a) Overview and objectives: iCCM in EGPAA, South Sudan, is part of MSF's broader portfolio to improve access to life-saving care in conflict-affected and hard-to-reach areas. MSF aims to reduce child mortality by bringing essential diagnosis and case management for malaria, pneumonia, and diarrhoea closer to communities through trained Boma Health Workers (BHWs). These iCCM activities officially launched in April 2022 and focus on delivering timely care to vulnerable populations living in remote areas.

b) **Populations served:** The iCCM interventions target approximately 200,000 people living across remote villages in Greater Pibor. Many of these communities are semi-nomadic, with movement patterns shaped primarily by seasonal water availability and livelihood needs. In Maruwa, a dry hotspot within the EGPAA project area, communities, mainly cattle keepers and their families, remain in town during the rainy season when water is sufficient, but migrate to known cattle camps during the dry season in search of water sources for livestock. Typically, only elders, the sick, and caregivers remain in town. Insecurity also influences movement patterns, affecting how people migrate (e.g., in smaller or larger groups), though it is the rainy season that determines where they go. These dynamics limit access to fixed health facilities and present challenges for continuous care. The EGPAA project team primary beneficiaries for iCCM are children under five, who are most at risk for illness and preventable deaths from malaria, pneumonia, and diarrhoea.

c) **Intervention Areas and Package of Services:** The iCCM interventions in EGPAA focus on the diagnosis, case management, and referral of common childhood illnesses at the community level. BHWs are trained and equipped to provide:

- iCCM for malaria (diagnosis and treatment for all ages), pneumonia, and diarrhoea
- Health promotion and disease prevention messaging within communities
- Referral support for severe cases requiring facility-based care
- Community sensitization to improve care-seeking behaviour and increased awareness of available iCCM services
- GBV services

d) **Key Benchmarks Addressed:**

- **Coordination and Policymaking:** Integration of iCCM into South Sudan's BHI, with BHWs serving as recognised members of the national health system.
- **Human Resources:** Recruitment and capacity building of BHWs under the BHI package, with plans for ongoing refresher training due to low literacy rates among health workers.
- **Supply Chain Management:** Coordination with health authorities for timely delivery of essential medicines and supplies, including contingency planning for the rainy season.
- **Service Delivery and Referral:** Provision of community-based diagnosis, treatment, and referral, with regular supervision and data collection to ensure quality.
- **Monitoring and Evaluation and Health Information Systems:** Routine data collection on iCCM consultations, treatment outcomes, and referral rates, is supported by regular analysis and reporting. Medical data from this intervention site in Southern Sudan were analysed over the period 2022-2024. The data are collected for the same pathologies as those presented for the other sites. Data for the three consecutive years for the quantitative analysis were fully downloaded from DHIS2. It should be noted that the wording of the indicators has changed over the years, although the interventions have remained the same. The data show a rather high level

of incompleteness, especially in 2024 for the site. In addition, data on effective referrals are rarely available.

e) **Achievements:** Successful training and deployment of 18 BHWs to deliver iCCM services, improved community awareness through sensitization campaigns, and strengthened supervision and supply chain systems to support BHWs in delivering timely care for malaria, pneumonia, and diarrhoea.

f) **Challenges:** Barriers include restricted access to remote areas during the rainy season, though this period is paradoxically less problematic for reaching semi-nomadic groups, as most of the population, including BHWs, returns to Maruwa and surrounding villages. During the dry season, BHWs migrate with their communities to cattle camps, as their recruitment was intentionally designed to ensure proximity and continuity of care for mobile populations. Additional barriers include low literacy levels among BHWs requiring ongoing coaching, and insecurity disrupting supervision and delivery of essential supplies.

g) **Future Directions:** Moving forward, iCCM activities in EGPAA will focus on strengthening integration with the formal health system through improved coordination with health authorities. Enhanced community engagement, particularly with traditional birth attendants and local leaders, will further promote iCCM services and encourage early care-seeking behaviour. Continued investments in supervision, training, and adapted data tools will aim to improve data quality and the overall performance of iCCM. Additionally, flexible strategies to reach mobile populations and those in remote cattle camps will be further developed to reinforce sustained coverage and impact

ICCM INTERVENTIONS IN KEBBI, NIGERIA

a) **Overview and objectives**: To respond to an ongoing nutrition crisis and high child mortality rates, within a context of conflict and violence, where no other actors are active, MSF initiated activities in Kebbi State, Nigeria. To place health indicators in context, if Kebbi was a country, its under-five mortality would be double that of Somalia; with malaria, pneumonia, diarrhoea accounting for 45% of U5M.[13] Key MSF objectives for iCCM interventions in Kebbi are to:

- Reduce mortality and morbidity among children aged 6-59 months in Kebbi State, particularly from pneumonia, malaria, acute watery diarrhoea, and malnutrition.
- Provide preventive care and community-based management of these conditions through the iCCM activities.

b) **Populations served:** Based on established needs, MSF's Kebbi project was started in March 2022 as an emergency intervention and, with fast and unexpected growing nutrition needs, it continued to function in an emergency mode until the end of October 2022. In response, in November 2022 (during

[13] MSF-OCB Kebbi Project Induction Presentation, SharePoint

the period of the 2023 ARO planning) a Routine Nutrition Assessment (RNA) was conducted in the local government areas (LGA) of Jega, Koko and Suru. Following the RNA, iCCM activities were started in April 2023 in 2 LGAs, Maiyama and Bagudo, and extended to Jega and Koko LGAs in 2024.

c) **Intervention areas and Package of Services:** The project provides case management for the main causes of childhood illness (malaria, acute watery diarrhoea and malnutrition) through iCCM, support of EPI (immunisation) and SMC (Seasonal Malaria Chemoprevention), health promotion (including key messages for pneumonia prevention), improvement of environmental health (EH)/infection prevention and control (IPC) to reduce infection risk in clinical settings, and qualitative curative care through free nutrition activities (in-patient and out-patient) for priority populations.

d) **Key Benchmarks Addressed:** The design and implementation of iCCM interventions in Kebbi have incorporated key operational approach benchmarks. These include:

- **Coordination and policymaking:** MSF developed and signed Memoranda of Understanding with the Kebbi State MOH to reflect and confirm agreed approaches for iCCM activities. Implementation of iCCM planning, training, supervision, monitoring and reporting activities are conducted jointly with MSF and LGAs teams.
- **Human resources:** iCCM activities are implemented by CORPs. CORPs receive monthly incentives that are processed through HR after they submit data. MSF conducted training to capacitate the CORPs to implement activities. Outreach NAM and iCCM Supervisors, with support from Health Promotion (HP) Managers and supervisors for preventive activities in the community take the lead in implementation and monitoring activities, working in collaboration with MOH (iCCM focal person for each LGA).
- **Service delivery and referral:** Referrals to PHCs established, but strengthening needed.
- **Communication and social mobilization:** Collaboration with Community Health Educators (CHEs).
- **Supervision and performance QA:** Monitoring and supervision conducted by NAM and ICCM Supervisor.
- **Monitoring and Evaluation and Health Information Systems**: Medical data from the Kebbi iCCM intervention in Nigeria were evaluated over the last two years of implementation (2023 and 2024). These data, almost completely absent from DHIS2, were received in Excel format and added to the database set up for the overall analysis, without any further processing. Not only is the data complete, but it can also be used to calculate indicators relating to the types of treatment received for cases of diarrhoea, confirmed malaria and respiratory infections. Expected result 1 of the logical framework for the year 2024 reports on some 3 iCCM indicators. The 2023 annual report was used for this evaluation.

e) **Achievements**: MSF launched iCCM interventions in four local government areas (LGA), trained CORPs, improved stock management, and strengthened collaboration with other projects.

f) **Challenges**: Budgetary constraints and delays in iCCM launch, reaching IDPs, late presentation of cases, and access to some communities.

g) **Future directions**: Other planned initiatives include Strengthening referral support and PHC capacity; Expanding preventive measures in the community; and Addressing challenges related to late presentation and access to communities.

ICCM INTERVENTIONS IN KENEMA, SIERRA LEONE

a) **Overview and objectives:** MSF iCCM interventions in Kenema, Sierra Leone, which started in 2022 (project began in 2021) and spans across nine PHUs, aim to reduce child morbidity and mortality in underserved and hard-to-reach communities by expanding access to life-saving treatments for malaria, pneumonia, and diarrhoea. The intervention aligns with national priorities and supports Sierra Leone's Free Health Care Initiative (FHCI) by strengthening community-based care and bridging the gap between communities and formal health services. The iCCM interventions are integrated into MSF's broader support to the health system in Kenema District, including outreach and community-based health services delivered through trained CHWs, who provide services at the community level, and CHAs, who are based at PHUs and serve as a bridge between community and facility-based care.

b) **Populations served:** The iCCM interventions prioritise children under five living in remote areas of Kenema District who face barriers to timely care. Pregnant and lactating women, as well as families in communities affected by flooding, displacement, and seasonal food insecurity, benefit indirectly from iCCM interventions through improved referral pathways to PHUs, strengthened community engagement, and integrated health promotion activities. These efforts help identify danger signs early, encourage timely care-seeking, and support broader maternal and child health outcomes beyond the under-five focus of iCCM.

c) **Intervention Areas and Package of Services:** The iCCM package of services focuses on the integrated management of childhood illnesses, specifically:

- Diagnosis and treatment of malaria, pneumonia, and diarrhoea.
- Early identification and referral of children with severe illness or danger signs.
- Community health promotion and education on key preventive health measures.
- Referral linkages between communities, supported PHUs, and the Kenema Government Hospital (KGH).
- Monitoring and reporting through the routine use of health registers and data systems.

d) **Key Benchmarks Addressed:** The iCCM interventions incorporate several key benchmarks, including:

- **Coordination and Policy Making:** Integration into national community health strategies and coordination with the District Health Management Team (DHMT) and Ministry of Health and Sanitation (MoHS).
- **Human Resources:** Selection, training, and supervision of CHWs and CHAs to deliver iCCM services and promote community health.
- **Service Delivery and Referral:** Provision of quality, community-based case management for malaria, pneumonia, and diarrhoea, with referral pathways to PHUs and KGH.
- **Supply Chain Management**: Ensuring the availability and timely replenishment of essential iCCM medicines and supplies at the community level.
- C**ommunication and Social Mobilization:** Community engagement and awareness-raising activities to promote the use of iCCM services and enhance health-seeking behaviours.
- **Supervision and Performance Quality Assurance:** Routine supportive supervision visits to CHWs to strengthen skills and ensure quality service delivery.
- **Monitoring and Evaluation and Health Information Systems**: Collection, review, and use of data from community-level registers to monitor service delivery, identify gaps, and inform project adjustments. The Kenema project is one of the sites whose medical data linked to iCCM interventions on the pathologies (malaria (test and treatment), diarrhoea, cough/rapid breathing, immunisation, referral and malnutrition) monitored are up to date on both the Excel and DHIS2 databases from December 2022 to December 2024. Referral data received in health facilities is the most consistent.

The indicators specific to the iCCM interventions at the levels of results 4 and 6 of the logical framework predate the period of implementation of the iCCM activities. Subsequent annual reports were not made available.

e) **Achievements:** The iCCM activities in Kenema have strengthened community-level access to essential child health services, improving early diagnosis and treatment for malaria, pneumonia, and diarrhoea. Strong collaboration with the DHMT has enhanced alignment with national policies, while supportive supervision and refresher training have reinforced CHW competencies.

f) **Challenges:** Persistent challenges include regular stockouts of essential medicines, particularly at PHUs, and gaps in the functionality of referral and counter-referral systems. Geographic barriers, limited transport options, and low levels of community awareness in some areas continue to hinder timely access to care.

g) **Future Directions:** Kenema's iCCM interventions will continue to align with the district's broader health system strengthening efforts, including improving supply chain reliability and enhancing community engagement strategies. As part of MSF's transition planning, efforts will focus on building the capacity of MoHS staff to manage and sustain iCCM activities and expanding community health promotion to address ongoing gaps in health-seeking behaviour.

ICCM INTERVENTIONS IN MASISI, DRC

a) **Overview and objectives**: Due to war and insecurity, nearly all humanitarian actors have left Masisi for Goma. MSF is the only partner supporting government efforts for mobilization to meet basic health needs. MSF has had to tighten security and staff movement. The security situation also has an impact on activities in the Muheto health area, including the relocation of activities to a health post in Busihe, following closure of the Muheto health centre. iCCM activities, started in March 2022 and currently implemented in two health areas aligned with a policy of one community relay (ReCo)/village located more than five kilometres from a health structure and coordination with the Community Animation Unit (CAC). In Masisi, traditional birth attendants (TBAs) also provide information and referrals for those affected by sexual violence information to women for ante- and post-natal care and referrals. Key objectives of iCCM activities are to:

- Reduce mortality among children in remote areas of Masisi Health Zone, DRC, by improving access to healthcare.
- Prevent, identify, and treat the three leading causes of community deaths: malaria, diarrhoea, and in the future to consider case management for pneumonia.
- Strengthen CHW capacity to provide care and refer cases with danger signs.
- Improve environmental health conditions, through health promotion and information.
- Revitalize, strengthen, and support the MOH community outreach system.

b) **Populations served:** The package of interventions is provided for children under five years of age in two villages located more than five kilometres from a health centre in Masisi Health Zone. While the target population size is unclear from the document review, each CHW is responsible for approximately 50 households. The two current community health sites are in the

- Kibugu/Bushenge Village, Muheto Health Area
- Kashunga Village, Ngomashi Health Area

iCCM interventions are developed and deployed six months after the start of MSF support to the health facility where stable care is available at the referral facility. There is also an assessment of other EH needs and technical support for the treatment of water sources, rehabilitation of existing water pumps, and rehabilitation or construction of latrines.

c) **Intervention Areas and Package of Services:** iCCM interventions in Masisi provide case management and referral activities for malaria (all ages), and diarrhoea (under 5 years). The package includes screening and referral for malnutrition, as well as recognition and referral of danger signs. Preventive activities include health promotion and hygiene education. At community level, TBAs also provide information and referrals for those affected by sexual violence information to women for ante- and post-natal care and referrals.

d) **Key Benchmarks Addressed:** The design and implementation of iCCM interventions in Masisi have incorporated key operational approach benchmarks. These include:

- **Coordination and policymaking:** MSF aligns with DRC's National Community Health policy and works alongside the MOH in implementation.
- **Human resources:** CHWs (RECOs and TBAs) are recruited with community leaders and CAC, with MOH and MSF training and support.
- **Service delivery and referral:** MOH and MSF are establishing referral pathways from RECOs to health centres, but challenges remain in ensuring referred patients reach health facilities.
- **Communication and social mobilization:** MSF is collaborating with TBAs and CHEs to promote iCCM services and disseminate health information.
- **Supervision and performance QA:** MSF and MoH supervisors conduct monitoring and supervision, with plans to further strengthen community ownership.
- **M&E and HIS:** MSF and MOH collect data through patient registers, medication records, and weekly activity reports, but the specific HIS is not mentioned. Quantitative medical data examined as part of this evaluation are those from October 2022 to December 2024 on the pathologies covered by the iCCM intervention, already mentioned above. These data, mainly downloaded from DHIS2, have significant incompleteness throughout the three years. For example, during the evaluation period, data related to immunisation were only available for two months. There is no reference in the logical framework to iCCM intervention data, which are expected to contribute to the reduction in mortality and morbidity.

e) **Achievements** include established collaboration with the MOH, the launch of iCCM interventions in two health areas, and training of CHWs.

f) **Challenges** include budgetary limitations, motivation of RECOs, delays in launching certain interventions (e.g., pneumonia), and difficulties in reaching some communities.

g) **Future directions:** MSF has reviewed plans to extend iCCM to 10 villages in the Muheto, Ngomashi, and Mahanga or Lukweti health areas (to be defined after evaluation), however these plans have been put on hold due to security constraints. Across all community health sites, MSF will continue to strengthen referral support and health centre capacity; improve environmental health conditions and water, sanitation, and hygiene (WASH) interventions; clarify the role of pneumonia treatment within the iCCM package with the MOH and ensure consistent training materials and approaches.

ICCM INTERVENTIONS IN NIONO, MALI

a) **Overview and Objectives:** MSF's Niono project is a healthcare initiative focused on improving access to and quality of care in the Niono health district of Mali. The project has a community-based approach, aiming to reduce morbidity and mortality, especially among vulnerable populations including children under 15, and pregnant women. The project operates in a complex humanitarian

context, marked by insecurity, population displacement, and a lack of healthcare providers. MSF seeks to provide free, quality care, and to strengthen the local health system.

b) Populations served: The primary beneficiaries of the project are:

- Children under 15 years old.
- Pregnant women.
- People who suffered a trauma

Internally displaced persons (IDPs). The project also aims to benefit the wider population in the intervention areas, particularly in Nampala.

c) Intervention Areas and Package of Services include:

- **iCCM:** The project implements iCCM for the management of common childhood illnesses: such as malaria, diarrhoea, acute respiratory infections and mental health at the community level.
- **Community Sites:** ASCs and ReCos also provide advice and care at home or in the community. They participate in mass campaigns, monitor vaccination records, and identify danger signs. ReCo also conducts postpartum home visits (VAD). The community sites offer free care for children 0-14 years old.
- **Nutrition:** The project supports nutritional screening t at the community and health centre levels. SAM cases identified in the community are referred to appropriate facilities. MSF also collaborates with other organisations to ensure the availability of nutritional supplements and treatment for malnourished children.

d) Key Benchmarks Addressed: The project aligns with several key benchmarks:

- **Policy**: The project supports Mali's national health policy and the national strategy for "*Soins Essentiels dans la Communauté*", particularly the provision of free healthcare for children under five, though challenges remain in place.
- **Human Resources:** MSF trains and supports ASCs and ReCos to deliver iCCM services, ensuring that communities have access to basic healthcare. The team also strengthens the capacity of health personnel through training and supervision and supports facilities in meeting WHO standards for staffing ratios. **Supply Chain Management**: MSF reinforces the availability of essential medicines and medical supplies at supported health facilities, addressing gaps in the national supply chain.
- **Service Delivery:** The project focuses on improving the quality of care, with regular supervision and training for healthcare providers to ensure adherence to protocols and standards as well as the accessibility, continuity, and iCCM. Health promotion activities are also essential. Epidemiological surveillance activities are strengthened with community health workers. Data is collected using the DHIS2 system.

- **Community Engagement**: The project actively involves community leaders, traditional healers, and other stakeholders in health promotion and service delivery, fostering local ownership and acceptance.
- **Monitoring and Evaluation and Health Systems**: The iCCM intervention quantitative data in Niono are evaluated over the period from 2021 (iCCM start year) to 2024. During this period, medical data were monitored. Some of the intervention indicators are included in the logical framework under Result 2. The annual reports for the four years of interventions have been made available and present each performance measure year by year. However, the data is stored both on DHIS2 and on Excel files. The data is received from the health system, from the health centre level, with little possibility of verification.

e) Achievements:

- **Increased Access to Healthcare**: MSF has significantly improved access to healthcare for vulnerable populations, particularly in remote and conflict-affected areas.
- **Reduction in Morbidity**: Through iCCM and community health interventions, the project has contributed to a reduction in morbidity due to malaria, diarrhoea, and ARIs among children under five.
- **Strengthened Health Systems**: MSF's support has improved the capacity of local health facilities, including health centres and referral centres; to deliver quality care and achieve health outcomes.

f) Challenges:

- **Insecurity:** The volatile security situation limits humanitarian access for the implementation and supervision of activities.
- **Health Desert:** The shortage of qualified health personnel and adequate infrastructure persists. Furthermore, there are restrictions on the hiring of staff who are not of certain ethnic backgrounds.
- **Logistical and Budgetary Challenges:** Financial and logistical constraints, including stockouts of essential medicines, can hinder operations.
- **Quality of Care:** Improving the quality of care and adherence to protocols remains a constant challenge.
- **Data Collection:** The project has faced challenges in data collection due to the context and strikes.
- **Free Health Care:** Some health personnel are reluctant to adhere to free health care policies in the community and even in the health centres.
- **Sustainability**: Ensuring the sustainability of healthcare services after MSF's eventual withdrawal remains a concern, particularly given the reliance on external support for essential services.

- **Community Resistance**: Some communities remain hesitant to seek prompt care or use formal healthcare services, preferring traditional healers or delaying care until conditions worsen.
- **Weak Health Infrastructure**: Limited resources and poor infrastructure in the Niono District pose challenges to service delivery, regular follow-up and monthly supervision.

g) Future directions: The Niono project aims to continue improving access to healthcare for vulnerable populations while addressing ongoing challenges. Key priorities for the future include:

- **Sustainability:** The project aims to build the capacity of communities and the local health system to ensure the sustainability of actions after MSF's departure. The project also plans for dialogue with the MOH and donors for effective implementation of free healthcare policies.
- **Improvements:** The project typically conducts a mid-term evaluation annually to assess the impact of activities and make necessary adjustments. Improving the quality of care, extending the project in hard-to-reach areas like Nampala, and better integration of services are central concerns for the coming years.

ICCM INTERVENTIONS IN TOMBOUCTOU, MALI

a) Overview and Objectives: The iCCM intervention aims to reduce child and maternal morbidity and mortality in the Tombouctou region by increasing access to free, high-quality healthcare. It focuses on strengthening community-based health services. In Tombouctou, iCCM is focused more generally on basic community care, with CHW sites (Sites ASC) acting as outreach points, providing healthcare to the whole community, regardless of age or illness. The initiative covers Tombouctou, Niafunké, and Goundam districts, supporting community health sites and referral facilities to enhance healthcare accessibility.

b) Populations served: The priority populations included in iCCM interventions serve broader age groups in response to identified health needs, particularly in conflict-affected and hard-to-reach areas, with a focus also on children 0-14 years old, pregnant women, and vulnerable groups across semi-nomadic communities.

c) Intervention Areas and Package of Services: The intervention package includes the management of malaria, acute respiratory infections, diarrhoea, and malnutrition, along with routine immunisation, maternal and newborn care, and community engagement through health promotion activities. Services are provided at community health sites.

d) Key Benchmarks Addressed:

- **Coordination & Policy**: Integration with MOH strategies, aligning with national health policies and the Basic Package of Health and Nutrition Services (BPHNS) framework.
- **Human Resources**: Capacity building through training for community health workers, nurses, and traditional birth attendants.

- **Service Delivery & Referral:** Strengthening community health centres and improving patient referral pathways to higher-level health facilities.
- **Supply Chain Management:** Ensuring the availability of essential medicines, malaria rapid diagnostic tests, and nutrition supplements at health sites.
- **Monitoring and Evaluation and Health Systems**: The iCCM intervention site in Tombouctou is similar to the one in Niono, except that annual reports have not been made available and some iCCM indicators are at the level of expected Outcome 1. The medical data are up to date in DHIS2 for the years 2023 and 2024. For the remaining intervention years, the data are stored in Excel files.

e) Achievements:

- Increased health access in remote and underserved communities, particularly through iCCM expansion and mobile outreach.
- Strengthened collaboration with regional health authorities, improving coordination in service delivery.
- Enhanced data collection and monitoring systems, including the integration of DHIS2 for routine reporting.

f) Challenges:

- Security risks due to ongoing conflict, limiting access to some areas and affecting service delivery.
- Supply chain disruptions, particularly in ensuring continuous availability of essential medicines.
- Logistical difficulties in reaching highly mobile and semi-nomadic populations, requiring adaptable service models.

g) Future directions: The project aims to expand coverage to additional remote communities, strengthen health worker training, and improve the sustainability of iCCM services through enhanced government and community ownership.

ICCM INTERVENTIONS IN YEI, SOUTH SUDAN

a) Overview and objectives: Beginning in 2016, iCCM activities in Yei, South Sudan, have been part of MSF's response to reducing mortality and morbidity in Yei River and Morobo counties by ensuring access to free, high-quality healthcare at the community level. iCCM activities focus on providing timely diagnosis, treatment, and referral for common childhood illnesses to populations affected by conflict, displacement, and limited access to health facilities. The specific objectives include increasing access to care for children under five and improving community-level case management through trained CHWs operating in remote and hard-to-reach areas.

b) Populations served: The iCCM intervention targets an estimated 630,000 people living in Yei and Morobo counties. This population includes IDPs, conflict-affected communities, and semi-nomadic seasonal cattle keepers. The priority group for iCCM services include children under five, who are at the highest risk of preventable deaths from malaria, diarrhoea, and pneumonia.

c) Intervention Areas and Package of Services:

The Yei iCCM intervention provides community-based management of childhood illnesses and supports the referral process for severe cases. Key services include:

- **Community case management** of malaria, pneumonia, and diarrhoea at designated iCCM sites and by CHWs.
- **Screening and referral** for SAM and danger signs requiring facility-based care.
- **Health promotion and community engagement** to increase awareness and timely care-seeking behaviour.
- **Routine data collection and reporting** to strengthen health information systems and monitor service delivery.
- **Supervision and capacity building** for CHWs to ensure adherence to treatment protocols, proper use of diagnostic tools, and high-quality care.

d) Key Benchmarks Addressed: The Yei iCCM intervention aligns with and addresses key iCCM benchmarks, including:

- **Coordination and Policymaking:** Collaboration with the MOH to align iCCM services with national guidelines and coordination through technical working groups.
- **Human Resources:** Recruitment, training, and ongoing supervision of CHWs to ensure effective service delivery.
- **Supply Chain Management:** Procurement and distribution of essential medicines, diagnostics, and treatment supplies for iCCM sites, with a focus on preventing stock-outs.
- **Service Delivery and Referral:** Provision of community-based treatment for childhood illnesses and a structured referral system for children needing higher levels of care.
- **Communication and Social Mobilization:** Community engagement and awareness-raising through health talks and collaboration with community leaders to promote iCCM services.
- **Supervision and Performance Quality Assurance:** Regular supervisory visits, use of supervision checklists, and on-the-job mentoring to strengthen CHW performance and adherence to treatment guidelines.
- **M&E and HIS:** Routine data collection at iCCM sites feeding into DHIS2 and internal MSF monitoring systems to track service delivery, performance, and outcomes. Medical data from Yei were analysed over the period 2022-2024. The data are collected for the same pathologies as

those presented for the other sites. Data for the three consecutive years for the quantitative analysis were fully downloaded from DHIS2. It should be noted that the wording of the indicators has changed over the years, although the interventions have remained the same. The data show a rather high level of incompleteness, especially in 2024 for the site. In addition, data on effective referrals are rarely available.

e) **Achievements:** MSF expanded iCCM coverage from two to nine sites, upgraded iCCM services to meet BHI standards, improved stock management and introduced motorbike and quad bike support to strengthen referral and supply chain systems. The project also saw an increase in outpatient consultations, antenatal care visits, and successful immunisation campaigns.

f) **Challenges**: Persistent security concerns limit CHW mobility, alongside difficulties in co-managing the interventions with the MOH and defining CHW roles.–Fluctuating prices, logistical barriers, and communication challenges.

g) **Looking Ahead**: Yei iCCM interventions aims to further strengthen the supply chain by improving coordination and responsiveness to prevent stock-outs, in alignment with MSF's procurement policies and national regulations. Additional priorities include improving coordination with the MOH to ensure clearer roles and responsibilities for CHWs and reinforcing CHW supervision and performance management. Future efforts will also focus on increasing community awareness and demand for iCCM services, integrating community feedback mechanisms, and enhancing data quality and use for decision-making.

ANNEX 4: LIST OF STAKEHOLDER GROUPS INTERVIEWED FOR THE INCEPTION REPORT

Affiliation	Stakeholder Group	Number of KIIs/FGDs
MSF OCB	Deputy Medical Director iCCM Thematic Evaluation Commissioner	1
MSF OCB	iCCM Thematic Evaluation Consultation Group Member, including: • Health Promotion, Community Engagement & Anthropology Advisor • Child Health and Paediatric Advisor • Medical officer Cell 3 • Malaria referent • Bujumbura Medical Coordinator	5
Project Sites (Cibitoke, Masisi, Kebbi, EGPAA, Yei, Niono, Tombouctou, Kenema)	Project Medical Referent	8*
MSF Mali, Niono	MSFOCB-Niono-NAM Outreach Coordinator	1
	Total Sample Size	**15**

ANNEX 5: ICCM STANDARD MEDICAL INDICATORS LIST – ICCM

Component	Indicator	Numerator	Denominator
General	Number of consultations done (for iCCM, count consultations among under 5)	By breakdown: Minimum: Age group 0-4; 5-14; 15+y. For iCCM: 2-11m, 12-59m, 5y+ Default: New/Follow up Contextual: by CHW or iCCM sites	Total number of consultations done
General	Proportional morbidities (for iCCM, count morbidities among under 5)	Total number of consultations done for a certain disease	Total number of consultations done (new and follow up)
General	Referral out rate (for iCCM, count among under 5 consultations)	Total number of sick children with danger sign(s) who are referred by CHWs	Total number of consultations done (new and follow up)
General	Average consultations per consultant a day (for iCCM, count among under 5 consultations)	Total number of consultations done	Number of consultants x Number of consultation days
iCCM	Proportion of children under 5 recommended for referral who are received at the referral facility	Number of cases under 5 recommended for referral and who are received at the referral facility	Number of cases under 5 recommended for referral
iCCM	Proportion of children under 5 that were correctly recommended for referral	Number of cases under 5 recommended for referral according to protocol	Number of cases under 5 who should be referred according to protocol as assessed by re-examination (by gold standard clinician)

iCCM	Proportion of CHWs who received at least one administrative supervisory contact in the prior 3 months during which registers and/or reports were reviewed	Number of CHWs who received at least one administrative supervisory contact in the prior 3 months during which registers and/or reports were reviewed	Number of CHWs trained in and deployed for iCCM
iCCM	Proportion of CHWs who received at least one clinical supervisory contact in the prior 3 months during which a sick child visit or scenario was assessed, and coaching was provided	Number of CHWs receiving at least one clinical supervisory contact in the prior 3 months where a sick child visit was observed, or scenario was assessed and coaching provided	Number of CHWs trained in and deployed for iCCM
iCCM	Proportion of CHWs who correctly count respiratory rate	Number of CHWs who correctly count the respiratory rate of live case, supervisor, community infant, or video	Number of CHWs assessed
iCCM	Proportion of CHWs who demonstrate correct knowledge of management of sick child case scenarios	Number of CHWs who demonstrate correct management of sick child case scenarios	Number of CHWs assessed
iCCM	Appropriate prescribing practices are used when results of RDTs are positive among children under 5	Number of children under 5 presenting with fever with a positive RDT who receive an ACT	Number of children under 5 presenting with fever with positive RDT
iCCM	Appropriate prescribing practices are used when results of RDTs are negative among children under 5	Number of children under 5 presenting with fever with a negative RDT who DO NOT receive an ACT	Number of children under 5 presenting with fever with negative RDT
iCCM	Proportion of Nutrition screening done (<5y)	Number of patients (<5y) screened for malnutrition	Total consultations (<5y)
iCCM	Proportion of Moderate Acute Malnutrition (<5y)	Yellow (>=115mm - <125mm) MUAC PLUS W/H or BMI Z score -3SD and -2SD among children <5	Total <5 screened for malnutrition status

iCCM	Proportion of SAM (<5y)	Any oedema PLUS Red (<115mm) MUAC PLUS W/H or BMI Z score < -3 SD among children <5	Total <5 screened for malnutrition status
iCCM	Proportion of children under 5 with up-to-date immunisation status	Number of children under 5 screens with up-to-date immunisation status	Total number of children under 5 screened for vaccination status
iCCM	Proportion of iCCM sites with no stock-outs of key iCCM medicines and diagnostics in the past month	Number of iCCM sites with no stock-outs of key iCCM medicines or diagnostics in the past month	Number of iCCM sites assessed
iCCM	Proportion of caregiver of children under 5 receives counseling on how to provide the treatment(s)	Number of children under 5 provided medicines where caregivers were provided proper counseling for provision of treatments (dose, duration, frequency and follow-up)	Number of cases of children under 5 prescribed medicines
iCCM	Proportion of children under 5 visiting a trained CHW who receive correct case management from that CHW (observed)	Number of children under 5 who were correctly treated/referred for all conditions	Number of children under 5 assessed requiring treatment and/or referral (observed)
General	Malaria test positivity	Positive tests	Total number of tests done

ANNEX 6: ICCM DOCUMENTATION LOG

The below table includes a list of priority documents consulted during the desk review for the IR. Further documentation will be gathered during KIIs.

Date	Document Description or Title	Document Type(s)
Core Documents		
2012	WHO and UNICEF Joint Statement for iCCM, titled "*An equity-focused strategy to improve access to essential treatment services for children.*"	Evidence and policy document
2015	MSF iCCM Workshop Materials	Slide decks (PowerPoint) and Meeting notes (Word)
2018	MSF iCCM Workshop Materials	Slide decks (PowerPoint) and Meeting notes (Word)
14.08.2018	Integrated Community Case Management, Ten Key Points - OCB	Strategy document (Word)
Unknown	World Vision iCCM tools for Planning and design, and Implementation quality improvement	Tools
Unknown	iCCM in Bili. Lessons learned: Implementation and bottlenecks	Feedback from HP debriefing (PowerPoint)
Unknown	iCCM Lessons Learned: *Analyse communautaire projet Bili*	Analysis of community mobilization for the Bili project (Word, French)
Ongoing	Paediatric Working Group SharePoint site - Country iCCM Guidance - iCCM Indicator Guide and Rapid Survey Tool	Various

Date	Document Description or Title	Document Type(s)
	- Project activity planning - WHO and country-specific iCCM training materials	
2018-2024	MSF Belgium Job Aides, shared with all MSF-OCB iCCM sites	iCCM Tools
2019	WHO and UNICEF technical meeting report, titled "*Institutionalizing integrated community case management (iCCM) to end preventable child deaths*."	Report
2021	MSF Clinical Nutrition Policy, Intersection Document, part of MSF's Medical Policy series	Policy
2021-2022	MSF's Clinical Nutrition Policy, Intersection Document, part of MSF's Medical Policy series UNICEF, Treatment of Wasting using Simplified Approaches, A Rapid Evidence Review USAID and Action Against Hunger, State of the Evidence for Modifications Aiming to Optimize Acute Malnutrition Management in Children under Five USAID Bureau of Humanitarian Assistance-led Training Toolkit on Simplified Approaches for the Detection and Treatment of Child Wasting	MSF Nutrition Evidence and Tools
	DMC 10 Pillars, providing guiding principles and links to key strategy, technical, and operational documents for all its 27 project sites where iCCM activities take place DMC Malaria case management algorithm DMC Community care package technical guidelines for DMC of malaria Short Guidance Rapid Needs Assessment for Community-based activities in DMC	MSF-Operational Centre Barcelona and Athens (OCBA) Decentralized Models of Care (DMC) documents and tools

Date	Document Description or Title	Document Type(s)
	Managing Malaria in the Community: Consultation and Assessment Module Recommended Supervision Strategies for Community Based Activities, DMC DMC Programme Logic Model, Indicators, Briefing Paper, and Malaria Job Aid, Evaluations of DMC Programmes in DRC, CAR, and South Sudan	
Burundi		
2023	Q2 Monitoring report	Project performance towards key indicators
2023	Cibitoke Logical Framework	Excel, List of indicators
2022	MONITORING REPORT - Projet Paludisme Burundi	Word document - Analytic description of the project for 2022
2022	Rapport Annuel 2022 - Narratif Projet Palu Burundi	Excel file for the follow-up of the activities and results
2023	2020 - 2023 Note conceptuelle projet palu Burundi	Word document - Summary of the project
2023	MONITORING REPORT - Projet Paludisme Burundi - Semestre 2023	Word document - Narrative of the project
2024	Operational Concept note	Word document, project description
2024	Document de stratégie de la promotion de la santé dans le District de santé de Cibitoke	Project and strategy description
DRC		

Date	Document Description or Title	Document Type(s)
2024	Masisi Logical Framework	Excel, List of indicators and Gantt
2022	Project MSF-OCB Masisi Feuille de Route 2022-24	PDF, Plan
2023	*Projet Masisi Rapport Annuel*	Word, Annual Report
Mali		
2021	*Plan stratégique national de soins essentiels dans la communauté*	National strategic plan
2021	*Stratégie HP communautaire projet Niono*	Project document
2024	ARO Mali Niono 2024	PDF, project document
Ongoing	Mali iCCM database 2020-2024	Excel Individual data and indicators
2023	*Cadre logique Niono*	Excel file with core indicators
2022	Annual Medical report Tombouctou	Report
2023	iCCM Project report Tombouctou	Word, annual report
2023	*Stratégie médicale TBT*	Project document
2023	*Cadre logique Tombouctou*	Excel, core indicators
2023	*Rapport annuel Tombouctou*	Report
Nigeria		
2024	EOM Handover Farayi Harume	Word, Handover report

Date	Document Description or Title	Document Type(s)
2024	Kebbi Project MOU 2024 Renewal	PDF, Signed MOU with the State MOH
2023	ARO 2024 Presentation	PowerPoint slide deck, Planning presentation
2023	MSF Preventive and community activities strategy for 2024	Word, Report
N/A	Kebbi Briefing	PDF, Slide deck
Sierra Leone		
21.02.2024	2024 Compilation of Project Documents for the Evaluation Process Sierra Leone- Kenema Project	Word Document - Includes a table with available documents for the evaluation process and the responsible contact
15.12.2023	MYARO Presentation 2024 Sierra Leone-Kenema Project	PowerPoint presentation - Provides project site description, health and humanitarian context, achievements and challenges, priorities, and timeframes
Ongoing	Quarterly Reports Sierra Leone- Kenema Project	Word documents and Excel - Provide quarterly progress updates on reaching expected results and project activities for the site. Also include updates to population demographics for the

Date	Document Description or Title	Document Type(s)
		site
South Sudan		
20.08.2022	iCCM Capitalization Report EGPAA Project – South Sudan	A supportive document for the update of the iCCM strategy for 2022-2023. A draft of this strategy was done but not updated since late 2021
06.2019	The Community Health System in South Sudan: The Boma Health Initiative- "*A community anchored health system for sustainable health sector development*" EGPAA Project- South Sudan	A technical document that presents BHI objectives, implementation guidance, institutional roles, geographic coverage, and service packages across the initiative.
10.2023	South Sudan ARO 2024	PowerPoint presentation - Provides project site description, health and humanitarian context, achievements and challenges, priorities, and timeframes
Ongoing 2024	Logframes EGPAA and Yei Projects- South Sudan	Excel sheets - Provides a breakdown of activities and timelines for each expected result (For EGPAA - ER 1 includes outreach activities for iCCM; For Yei - ER 4 includes iCCM activities and immunisation

Date	Document Description or Title	Document Type(s)
		coverage)
2024	Red Organogram EGPAA Project-South Sudan	Excel sheet - Presents overview of staff positions and departments for EGPAA project
Ongoing	South Sudan Site Visit Reports EGPAA and Yei Projects -South Sudan	Word documents - Variety of reports written by MSF staff that document project findings, recommendations, and ongoing activities

ANNEX 7: KEY INFORMANT INTERVIEWS AND FOCUS GROUP DISCUSSIONS BY STAKEHOLDER GROUP AND TYPE

In collaboration with the SEU and with guidance from the Consultation Group, the Evaluation team developed a detailed list of key informant groups and types by project and by level—from community to global—to ensure comprehensive sampling and representation across gender, age, demographic, and professional backgrounds. For each category at the country level, we specified how key informants were selected across projects through remote and in-person interviews conducted across the eight MSF-OCB iCCM interventions to address the five priority evaluation questions. Below, we also note cases in which participant groups were under- or over-sampled.

Affiliation	Stakeholder group/type	Planned Sample size	Final Sample Size
***Community Member/ Parent or Caregiver** Community-level interviews were carried out across multiple sites using both in-person and remote modalities, depending on availability and feasibility. Although initial input from MSF-OCB Technical Staff suggested this group might be limited to EGPAA, the Evaluation Team collaborated closely with Project staff to expand participation to additional sites. This group was ultimately **over-represented** due to strong community engagement and the active support of MSF Project teams in facilitating the interviews.			
Community	Community Leaders	4	13
Community	CHWs	4	10
Community, MOH, MSF	Parent, caregiver	4	9
	Total:	12	32
MSF Project Staff A total of 45 interviews were conducted with MSF Project Staff across the eight MSF-OCB iCCM projects. Informants included a range of roles such as iCCM Activity Managers or Supervisors, PMRs or Deputy PMRs, Health Promotion and Advocacy staff, Project Coordinators, and support staff in data, pharmacy, supply, HR, and finance. This group was ultimately **over-represented** due to strong engagement and the active collaboration of MSF Project staff in			

facilitating the interviews.			
MSF Project	Health promotion, Advocacy activity manager or supervisor	4	11
MSF Project	Nurse (facility)	2	1
MSF Project	iCCM Activity Manager (nurse) or Supervisor	8	12
MSF Project	Data officer or manager	3	5
MSF Project	HR/Admin/Finance Manager	2	1
MSF Project	Supply Manager	1	4
MSF Project	Pharmacy Manager	2	2
MSF Project	PMR or Deputy PMR	8	5
MSF Project	Project Coordinator	3	4
	Total:	33	45
MOH Representatives During in-person visits to selected MSF-OCB iCCM project sites, the Evaluation Team organised courtesy visits and conducted key informant interviews with MOH representatives at the community, district, and central levels. Interviewees included referral health facility providers, district health management team members, and representatives from the National Malaria Programme and the Department of Maternal and Child Health. No interviews were conducted at the regional level due to availability constraints. A total of 15 interviews were completed for this group, which was **slightly over-represented.**			
MOH - Community level	Referral health facility in charge, provider (in facilities where CHWs refer patients with danger signs)	4	7
MOH - District	District health management team member	2	5

level			
MOH - Regional level	Regional health management team member	2	0
MOH - Central level	National Malaria Programme, Case management focal point or another team member	3	2
MOH - Central level	Department of Maternal and Child Health	2	1
	Total:	13	15

MSF Coordination Team

At the coordination level, the Evaluation Team aimed to interview approximately 1–2 key informants from each of the eight MSF-OCB projects with iCCM interventions. This included Medical Coordinators, Heads of Mission, Pharmacy and Advocacy Coordinators, and HR, Finance, and Supply/Logistics Coordinators. However, this group was **under-represented**, with only 7 interviews completed out of a planned 14. Challenges included limited availability, declined participation, and a preference among some respondents for us to speak with staff at the project level who were more directly involved in iCCM implementation.

MSF Coordination	Medical Coordinators	6	4
MSF Coordination	Heads of Mission	2	1
MSF Coordination	Pharmacy Coordinators	2	1
MSF Coordination	Advocacy Coordinators	2	0
MSF Coordination	HR/Admin or Finance Coordinator	1	1

MSF Coordination	Supply Chain/ Logistics Coordinator	1	0
	Total:	14	7

RST/Cell

For the RST/Cell level, the Evaluation Team aimed to conduct seven interviews, including Cell Coordinators (or their designates), Medical Officers, Deputy Cells or Regional Medical Team Leaders, HR or Finance Officers, and Epidemiology Advisors. However, this group was **under-represented**, with only three interviews completed. Like the Coordination Team, some individuals were unavailable or opted not to participate, and several referred us to colleagues at the country or project level who were more directly involved in iCCM implementation and could provide more detailed insights.

RST/Cell	Cell coordinator (or their designate)	1	1
RST/Cell	Medical Officer /Dep Co /Regional medical team leader	3	2
RST/Cell	HR or Finance Officer	1	0
RST/Cell	Epidemiology Advisors	2	0
	Total:	7	3

MSF-OCB Technical Staff – Medical department

The Evaluation Team aimed to interview eight MSF-OCB Technical Staff members from the Medical Department, including advisors on malaria, health promotion, nutrition, sexual and reproductive health, vaccination, epidemiology, and e-health, as well as the Deputy Medical Director and Paediatric Advisor. A total of 11 interviews were conducted, making this group **slightly over-represented**. The only notable gap was the Sexual and Reproductive Health Advisor, who declined to participate. Oversampling occurred in part due to strong engagement from the health promotion team and the inclusion of additional relevant technical profiles who contributed valuable insights across the benchmarks.

MSF-OCB	Deputy Medical Director	1	1
MSF-OCB	Paediatric Advisor	1	1

MSF-OCB	Technical Advisor - Malaria	1	1
MSF-OCB	Technical Advisor - Health promotion	1	3
MSF-OCB	Technical Advisor - Nutrition	1	1
MSF-OCB	Technical Advisor - Sexual and Reproductive Health	1	0
MSF-OCB	Technical Advisor - Vaccination	1	1
MSF-OCB	Technical Advisor - Epidemiology, E-Health Unit	1	1
MSF-OCB	Other	2	2
	Total:	8	11
Global iCCM Stakeholders The Evaluation Team aimed to conduct two interviews with global stakeholders engaged in iCCM, including representatives from organisations such as UNICEF, CRS, World Vision, and others. This target was **fully met**, with two interviews completed. These stakeholders provided high-level perspectives on global policy, technical guidance, and funding priorities related to iCCM.			
Global iCCM stakeholders	UNICEF, CRS, World Vision, and/or others	2	2
	Total:	2	2
	Final Sample Size	90	115

*Note: An additional 5-6 participants will be sampled from this group for each project site during the case studies in the form of an FGD.

ANNEX 8: INTERVIEW QUESTIONS

Following desk review and consultation with global iCCM implementation experts, the evaluation team has developed a comprehensive set of questions below aligned with the eight established inter-agency benchmarks for iCCM implementation (referred to as programmatic areas). The benchmarks used are those presented in the *WHO and UNICEF Joint Statement for iCCM: An equity-focused strategy to improve access to essential treatment services for children,*[14] and the USAID Maternal and Child Health Programme *Indicator Guide: Monitoring and Evaluating Integrated Community Case Management*,[15] recognised to be the most recent source of global iCCM information and resources. The evaluation team will ask each key informant or groups of key informants (through FGDs) a subset of the questions below.

Programmatic Area	Interview Question
1. Coordination and Policy Making	1.1 Are national policies and guidelines in place to support community-level treatment, including iCCM? Could you provide a mapping of current iCCM interventions, partners involved, and any national coordination mechanisms for iCCM? 1.2 Does your country have a national community health strategy, and how does your iCCM intervention align with it? Are there areas where your intervention goes beyond national guidelines, such as offering family planning services or managing uncomplicated cases of malnutrition, or are there gaps where the national strategy could be expanded? 1.3 What are the MSF and/or MSF-OCB vision and goals for health in the countries where you work and through the project activities that you implement? What is the role of iCCM in supporting this vision? How does iCCM fit within overall MSF goals? 1.4 How are the iCCM activities designed, and who makes the decisions regarding the intervention package, priority groups, and harmonization with other activities? To what extent and in what ways are community members involved in needs assessment for and the decision-making process for these activities? 1.5 Did you conduct a needs assessment and/or situational analysis prior to or during iCCM implementation? If yes, can you describe the needs assessment? Can we share a copy of the assessment report/results? (Probe per WHO/UNICEF): Did it include geographical mapping of communities suitable for iCCM; national policies and guidelines in place

[14] WHO/UNICEF (2012).

[15] Child Health Taskforce, Integrated Community Case Management (iCCM) website https://www.childhealthtaskforce.org/hubs/iccm

	to allow treatment at the community level; mapping of current CCM activities and partners; and a national coordination mechanism for iCCM? How was the community involved in the assessment of iCCM needs? 1.6 Do you have a project plan describing the approach for each key benchmark area? Was your project plan developed in consultation with the MOH? With partners? 1.7 Which components of iCCM are included in your project? Why? 1.8 What adaptations have been made to the global standard iCCM model (c.f., https://www.childhealthtaskforce.org/hubs/iccm) in response to local needs and conditions? Can you describe these adaptations and the reasons behind them? 1.9 Who are the key iCCM stakeholders at national, district, and community level and how do you coordinate with them? How are different stakeholders (e.g., MOH, district health authorities, community leaders, health workers, local authorities) involved in the planning and execution of iCCM activities? 1.10 Which methods are used to engage the community in iCCM activities? Which methods have been most effective, and why? How was the community involved in determining health needs and design of iCCM interventions? 1.11 How do MSF and local health authorities collaborate on iCCM interventions? What are the key challenges/lessons and successes of those collaborative efforts? 1.12 What roles do external donors, normative, technical, and implementing partners play in the iCCM interventions? 1.13 With which MOH/health technical working groups does the MSF team coordinate? How often does the MSF iCCM team join TWG/coordination meetings? 1.14 Are there other settings within your project, country, or region where you believe iCCM could be a valuable strategy but is not currently implemented? If so, could you explain why it has not been implemented in those areas? Are there specific feasibility challenges or other hurdles that may be preventing its implementation? 1.15 Which factors have influenced the effectiveness of coordination between various stakeholders involved in iCCM? 1.16 How have the policies and guidelines for iCCM been received by various stakeholders including the MOH, healthcare providers, CHWs, and communities? What specific challenges or facilitators have impacted their adoption? 1.17 How are iCCM interventions aligned with and implemented according to standardized guidelines and national policies at the community level,

	and what challenges or facilitators impact this process? 1.18 How have iCCM intervention outcomes been sustained within the project or region, and what specific approaches have been effective in doing so? How can iCCM interventions be sustained in case/after the end of MSF project support?
2. Costing and Financing	2.1 Can you describe the approach for costing iCCM activities to ensure that necessary financing is secured? (JS) Can you share the project budget and cost breakdowns (by line items to calculate % expenditures by cost category)? 2.2 How can MSF improve support for the sustainability and scalability of iCCM initiatives? 2.3 Funding - How are MSF iCCM activities funded, and are there future funding sources available? What strategies are in place to ensure the consistent supply of necessary resources and medications? 2.4 How are budget decisions made, and what are the primary challenges and facilitators influencing these financial decisions for iCCM? 2.5 What financial models or strategies have been/could be in the future implemented to ensure the long-term sustainability of iCCM projects?
3. Human Resources	3.0 How are CHWs selected by communities, and what are the criteria for their selection? Are CHWs recognised as part of the MOH workforce, and what tasks are they officially allowed to perform? Additionally, have the iCCM activities built upon existing community health initiatives, or did MSF need to establish these activities from scratch? 3.1 Do you have a written TOR describing clear and well-articulated roles and responsibilities for CHWs? 3.2 How are CHWs trained, at the start of the intervention and over time? How are CHWs supervised? Which resources and tools (e.g., job aids, supervision checklists) are available to support training and supervision? 3.3 Are MOH, health facility, and/or community structures or mechanisms in place to support CHWs? If yes - can you describe the structures/mechanisms, and do they have TOR for their roles and responsibilities? 3.4 Do you have a written TOR for iCCM intervention staff? For MOH collaborators? For community structures which support CHWs? 3.5 What is the percentage of male/female CHWs? What is the age range of CHWs? What is the geographic and cultural representation of CHWs in your iCCM interventions? What educational level and professional background do the CHWs in your iCCM interventions have?

	3.6 Do you have strategies in place for iCCM personnel and CHW retention and motivation? If yes, please describe. 3.7 How do the number and geographic distribution of CHWs correlate with the needs of the target population, and what efforts are made to ensure adequate and equitable coverage? 3.8 How do CHWs assess their effectiveness in delivering iCCM services and what challenges do they face?
4. Supply Chain Management	4.0 Are appropriate 'child-friendly' medicines and supplies for iCCM included in the national essential medicines list; and procurement plan, inventory control, resupply logistics system and LMIS for iCCM with standard operating procedures? Are these available to CHWs? 4.1 Can you describe the procurement and supply chain for key iCCM commodities? 4.2 Which iCCM commodities are in/out of stock now? Which iCCM commodities have experienced stock-out in the past 12 months? What was the duration of the stock-out? How was the stock-out resolved? 4.3 How are iCCM diagnostic tools and medicines stored in CHW homes/worksites? Do CHWs have access to a secure/locked storage area for iCCM commodities? 4.4 How do CHWs re-stock essential supplies, and what is the frequency and process for restocking? What tools or systems are in place to facilitate this process? Are CHWs linked with health facilities for re-supply, and how does this support the sustainability of iCCM activities beyond the project end? 4.5 How are supply and distribution challenges in general and in hard-to-reach areas addressed to ensure adequate availability of iCCM supplies? 4.6 How have supply chain challenges affected the effectiveness and scalability of iCCM interventions? 4.7 Which long-term strategies have been established to maintain and improve the supply chain for iCCM commodities?
5. Service Delivery and Referral	5.0 Are appropriate guidelines in place for clinical assessment, diagnosis, management and referral, including plans for rational use of medicines (and RDTs where applicable); and referral and counter-referral system for iCCM? If yes, can you share a copy for our files. 5.1 Please confirm the geographic, population, and contextual details of the project site. Additionally, how were key decisions regarding iCCM implementation made, including site selection, human resources management, supervision, and care packages? How were communities

	involved in these decisions, and what data and stakeholders informed the process? 5.2 Which iCCM activity components are included in your iCCM intervention (malaria, pneumonia, diarrhoea)? Is the targeted population asking for other services? If yes, which? 5.3 How do CHWs organise their work practically? Where do they see the patients? Where do they store medicines? How do they track and report case management? What do they struggle with? 5.4 Are other services incorporated into your iCCM activity portfolio? If yes, which services? How are they incorporated? 5.5 Which age groups are included in iCCM activities and other services? Which packages of care are provided for which health areas/disease, including the standard iCCM package as outlined above and/or additional community health interventions (e.g., nutrition)? 5.6 How do CHWs manage malaria RDT-negative results? 5.7 How do CHWs manage danger signs of severe disease? Where are the nearest referral services provided? Please describe the referral facility and available services. What are the challenges to referring cases? Are any mitigation measures in place for transport and/or follow-up of referred patients? 5.8 What percentage of cases presenting to CHWs are referred for treatment? What percentage completes the referral? How are outcomes tracked post-referral? 5.9 To which facility/provider do CHWs refer patients needing care for severe illness or specialized care? What are the barriers to referral? How are referrals tracked from community to facility level? 5.10 Have any other project activities included use of rectal artesunate for pre-referral treatment? If yes, please describe. 5.11 Do CHWs have tools to support the counting of breaths for children with suspected pneumonia? If yes, please describe. 5.12 What proportion of the target population has access to iCCM services, and which areas or groups remain underserved and why? 5.13 How effectively have the service delivery and referral practices been integrated into daily operations by health workers and community members? What barriers or supports have influenced their adoption? 5.14 How are/will the long-term sustainability and quality of iCCM service delivery and referral practices ensured?
6. Communication and Social Mobilization	6.1 Do you have a communication and social mobilization plan and strategy in place for iCCM? Do you have materials and messages for iCCM? If yes, please share.

	6.2 How are community influencers involved in health promotion, support of iCCM? 6.3 How effectively are communication and social mobilization efforts reaching and engaging diverse groups within the target population? 6.4 How widely have the iCCM communication and social mobilization efforts been embraced by community leaders, health workers, and the public? What are the main factors that have either facilitated or hindered their widespread adoption? 6.5 What long-term strategies are in place to ensure the sustainability of communication and social mobilization efforts for iCCM?
7. Supervision and Performance quality improvement	7.1 Does the project have a plan and appropriate tools to support effective supervision, trained supervisors, and resources (e.g., vehicles, fuel) to conduct supervision and provide skills coaching to CHWs? If yes, please share. 7.2 Do you have a comprehensive basic and refresher training plan for CHWs? If yes, please describe. 7.3 How are MOH teams from central, district, and facility levels involved in training CHWs? 7.4 Which training curricula and tools are used to train CHWs? 7.5 Can you describe the training process for CHWs involved in iCCM? What are the strengths and weaknesses of the current training model? How is ongoing support and capacity building ensured for the staff involved in iCCM? 7.6 Can you describe the approach to and frequency of supervision visits? (Probe for: integrated supervision with district or zonal MOH medical officers; project-led supervision; frequency; contents of/tools for supervision; contents of supervision) 7.7 Which supervision checklists and tools are used during supervision visits? 7.8 How are gaps in CHW capacity managed following supervision visits? (Probe for mentoring, on-the-job training, other approaches for ongoing capacity strengthening.) 7.9 How are the accessibility of supervision and quality improvement measures ensured for CHWs, especially in remote and underserved areas? 7.10 What are the long-term strategies to maintain and enhance the effectiveness of supervision and quality improvement practices for iCCM?

8. Monitoring and Evaluation and Health Systems	8.1 Do you have a comprehensive monitoring framework and system for all iCCM components, integrated within the national health sector plan and health information system, as well as MSF's internal monitoring systems? If yes, please describe how these systems are aligned and share any relevant documents. 8.2 Can you share an example of the health register used to record each patient visit? How is this register used both at the community level and within MSF's internal data monitoring processes? 8.3 How are monthly health register data shared with the health facility for recording in the district/national HMIS? Additionally, how is this data used within MSF to monitor and adjust project activities? 8.4 What mechanisms are in place to monitor and evaluate the outputs outcomes of iCCM activities? (Probe for routine monitoring, evaluations, patient feedback, and other approaches) 8.5 How are data collected, monitored, analysed, and discussed internally within MSF? Who is involved in this process, and what tools or systems are used to facilitate it? Are CHWs or other community members involved in this data review and analysis process? If so, how? 8.7 How are M&E and HIS systems adapted to ensure comprehensive coverage and accessibility across all targeted regions and for all CHWs? 8.8 What are the main challenges and successes in using M&E and HIS to track and report on iCCM outcomes?
9. Cross-cutting Overarching Questions	**Challenges and Barriers** 9.1 What are the primary challenges you face in the implementation of iCCM activities? 9.2 What are your support structures/resources in place to mitigate those? 9.3 Are there any cultural, logistical, or resource-related barriers that hinder the effectiveness of iCCM activities? How are these addressed? 9.4 Can you share a particular lesson learned from iCCM activities? 9.5 What is your security context and how does this affect iCCM interventions in your project? **Success Factors** 9.6 Which elements of the iCCM activities do you consider most successful, and what impact have they had on the community? 9.7 Can you share a particular success story or a significant positive outcome from the iCCM activities? **Recommendations for Improvement**

	9.8 Based on your experience, what changes or improvements would you recommend for the iCCM activities? 9.9 Are there new strategies or tools that you think should be integrated into the iCCM activities to enhance effectiveness? **Future Directions** 9.10 Looking forward, what are the most pressing needs or opportunities for expanding or adapting iCCM activities? 9.11 Which types of information from this evaluation may be most useful for you in managing the current (and future) iCCM intervention(s)? (Probe for: lessons and/or innovations from other projects; best practice tools developed/shared; new funding opportunities to grow/expand/extend the project or develop new ones)

ANNEX 9: INFORMED CONSENT FORM (INDIVIDUAL IN-DEPTH INTERVIEWS)

Evaluation Title: Thematic Evaluation of MSF's Integrated Community Case Management (iCCM) Projects
Evaluation Team: Mary Kante, Laure Moukam, Malia Skjefte
Description of Key Stakeholders: Stakeholders involved in or impacted by iCCM activities, including CHWs, community members, patients, PMRs, commissioners, and Coordination Group members
Version Date: 1.0

This form provides important information about participating in this evaluation. You have the right to take your time in making decisions about participating in this evaluation.

If you have questions or concerns, please email Linda Ohman at Linda.ohman@stockholm.msf.org.

Who is the evaluation team?

We are an evaluation team from Eau Claire Consulting, working under the management of the Stockholm Evaluation Unit. We are conducting an evaluation titled "Thematic Evaluation of MSF's Integrated Community Case Management (iCCM) Projects."

Evaluation Purpose

This evaluation will help us and future evaluation teams from MSF better understand current difficulties or challenges that CHWs, healthcare providers, authority figures, and community members face in the implementation and outcomes of iCCM activities. Results from this evaluation will allow teams to develop more effective strategies for community health management and intervention.

Why am I being invited to take part in this evaluation?

We want to know more about the experiences of stakeholders involved in or impacted by iCCM activities. You are eligible to participate in this evaluation if you:

- Are involved in or impacted by iCCM activities
- Are at least 18 years old

- Agree to be interviewed

What should I know about this evaluation?

- Someone will explain this evaluation to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.
- You can choose to withdraw from the evaluation at any point during the evaluation period.

How long will I take part in this evaluation?

You will have 1 total interview. The interview will last about 45-60 minutes and will be audio-recorded. You may skip any questions during the interview process. You are welcome to ask for any clarification or ask follow-up questions.

We will collect the following information:

- Socio-Demographic characteristics
- Overall experience with iCCM activities
- Challenges related to iCCM activities (Social, Health, Operational)
- Recommendations for how to improve future iCCM activities

Will I be compensated?

You will not be compensated for this interview.

What are the benefits?

There are no direct benefits to completing this interview. You will help your community and MSF by improving knowledge about iCCM activities, which will aid future iCCM interventions across the MSF-OCB portfolio.

Could this evaluation be bad for me?

You may feel uncomfortable sharing private and sensitive information about your experiences with iCCM activities. We plan to minimize any potential risks or discomfort by asking questions in a sensitive manner and by training all evaluators before interviews are conducted. There's no consequence if you want to skip questions or stop at any time. For Zoom interviews, the interviewer will be in a confidential and safe

area during the call to ensure privacy, and we also recommend that you participate in a safe, secure, and private location. In-person interviews will also take place in a safe, secure, and private location.

All information, including the interview recording, will be stored on a password-protected Google Drive. The coded transcriptions may be shared with ECC and the Stockholm Evaluation Unit for future evaluation purposes. To protect your privacy, you will not be named or identified in any shared or public reports or publications resulting from this evaluation. All data will be anonymized to ensure confidentiality.

What if I do not want to be in this evaluation?

Participation in this evaluation is completely voluntary. You can decide to participate or not to participate. Withdrawing or refusing consent from the evaluation does not impact the services you receive from MSF or the MOH.

Statement of Consent

I have been asked whether I consent to participate in this evaluation. A team member has explained the information in this consent form including risks and possible benefits. All my questions about the evaluation have been answered to my satisfaction. I know that I can stop and leave the evaluation at any time without any impact on services or resources available to me from MSF.

[Verbal consent is then collected on Zoom recording; Written consent is provided for in-person interviews.]

ANNEX 10: INFORMED CONSENT FORM (FOCUS GROUP DISCUSSION)

Evaluation Title: Thematic Evaluation of MSF's Integrated Community Case Management (iCCM) Projects
Evaluation Team: Mary Kante, Laure Moukam, Malia Skjefte
Description of Key Stakeholders: Stakeholders involved in or impacted by iCCM activities, including CHWs, community members, patients, PMRs, commissioners, and Coordination Group members
Version Date: 1.0

This form provides important information about participating in this evaluation. You have the right to take your time in making decisions about participating in this evaluation.

If you have questions or concerns, please email Linda Ohman at Linda.ohman@stockholm.msf.org.

Who is the evaluation team?

We are an evaluation team from Eau Claire Consulting, working under the management of the Stockholm Evaluation Unit. We are conducting an evaluation titled "Thematic Evaluation of MSF's Integrated Community Case Management (iCCM) Projects."

Evaluation Purpose

This evaluation will help us and future evaluation teams from Médecins sans Frontières (MSF) better understand current difficulties or challenges that CHWs, healthcare providers, authority figures, and community members face in the implementation and outcomes of iCCM activities. Results from this evaluation will allow teams to develop more effective strategies for community health management and intervention.

Why am I being invited to take part in this evaluation?

We want to know more about the experiences of stakeholders involved in or impacted by iCCM activities. You are eligible to participate in this evaluation if you:

- Are involved in or impacted by iCCM activities
- Are at least 18 years old

- Agree to be interviewed

What should I know about this evaluation?

- Someone will explain this evaluation to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.
- You can choose to withdraw from the evaluation at any point during the evaluation period.

How long will I take part in this evaluation?

You will participate in 1 focus group discussion with around 4-6 other participants. The discussion will last about 45-60 minutes and will be audio-recorded. You may skip any questions during the interview process. You are welcome to ask for any clarification or ask follow-up questions throughout the interview.

We will collect the following information:

- Socio-Demographic characteristics
- Overall experience with iCCM activities
- Challenges related to iCCM activities (Social, Health, Operational)
- Recommendations for how to improve future iCCM activities

Will I be compensated?

You will not be compensated for this interview.

What are the benefits?

There are no direct benefits to completing this interview. You will help your community and MSF by improving knowledge about iCCM activities, which will aid future iCCM interventions at MSF.

Could this evaluation be bad for me?

You may feel uncomfortable sharing private and sensitive information about your experiences with iCCM activities. We plan to minimize any potential risks or discomfort by asking questions in a sensitive manner and by training all evaluators before interviews are conducted. There's no consequence if you want to

skip questions or stop at any time. The discussion will take place in a confidential and safe space to ensure privacy.

When participating in a focus group discussion, there is a risk that other participants may share the details of what is discussed outside the group. To mitigate this, we will emphasize the importance of confidentiality to all participants before starting the discussion and encourage everyone to respect the privacy of others by not sharing any personal or sensitive information discussed during the session. Despite these precautions, we cannot guarantee that all participants will adhere to this confidentiality agreement.

All information, including interview recordings and focus group discussions, will be stored on a password-protected Google Drive. The coded transcriptions may be shared with the Stockholm Evaluation Unit for future evaluation purposes. To protect your privacy, you will not be named or identified in any public reports or publications resulting from this evaluation. All data will be anonymized to ensure confidentiality.

What if I do not want to be in this evaluation?

Participation in this evaluation is completely voluntary. You can decide to participate or not to participate. Withdrawing or refusing consent from the evaluation does not impact the services you receive from MSF or the MOH.

Statement of Consent

I have been asked whether I consent to participate in this evaluation. A team member has explained the information in this consent form including risks and possible benefits. All my questions about the evaluation have been answered to my satisfaction. I know that I can stop and leave the evaluation at any time without any impact on services or resources available to me from MSF.

[Verbal consent is then collected on Zoom recording; Written consent is provided for in-person interviews.

ANNEX 11: KEY FINDINGS FROM QUANTITATIVE ANALYSIS

In this annex, the medical data generated at each project site were analysed for the period of the intervention. The results are presented below in terms of historical trends over the years in which the intervention was implemented and according to the main medical indicators for community management of pathologies in children under five. Detailed analyses by project sites are presented after each indicator's annual trends.

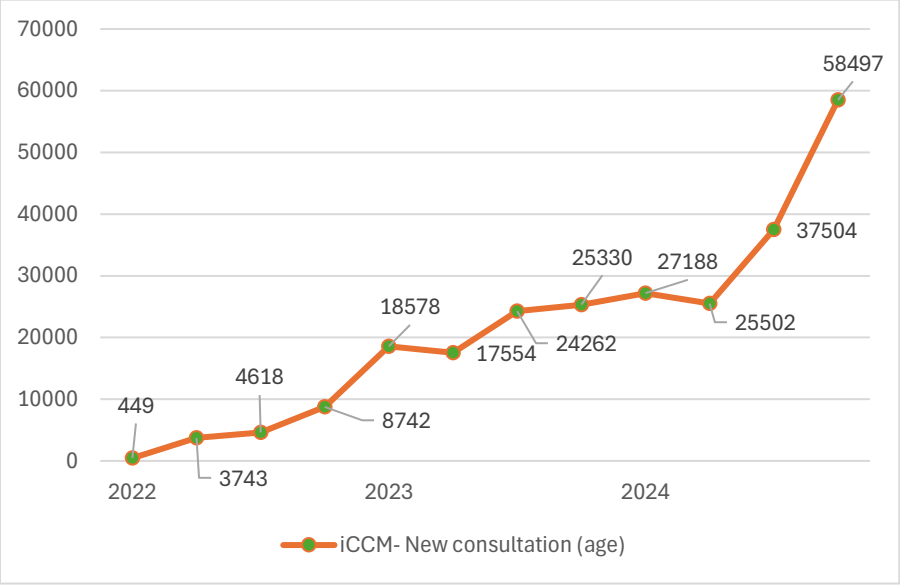
It should be noted that the comparative analyses by project site, although covering the same period (2022-2024), do not include data from Kebbi (Nigeria). This is because the Kebbi data format was unavailable when the data was downloaded from DHIS2. Missing values in headcount data—whether isolated or spanning multiple months at specific sites—were treated as true zeroes, assuming that no individuals were present. While this approach simplified the computation of indicators, it may have introduced downward bias in the results, particularly in cases where missing data did not reflect an actual absence of individuals. Furthermore, inconsistencies found in data reported in some cases produce unrealistic trends or figures for certain indicators.

For each indicator, we have analysed available data to show trends over time and across MSF-OCB projects with iCCM activities.

11.1 Consultations (new)

This measures the total number of new consultations for all ages. The numerator is the number of new consultations recorded. Missing values occur for Tombouctou and Niono in 2022.

Figure 1 Number (n) of new iCCM consultations in OCB, 2022-2024

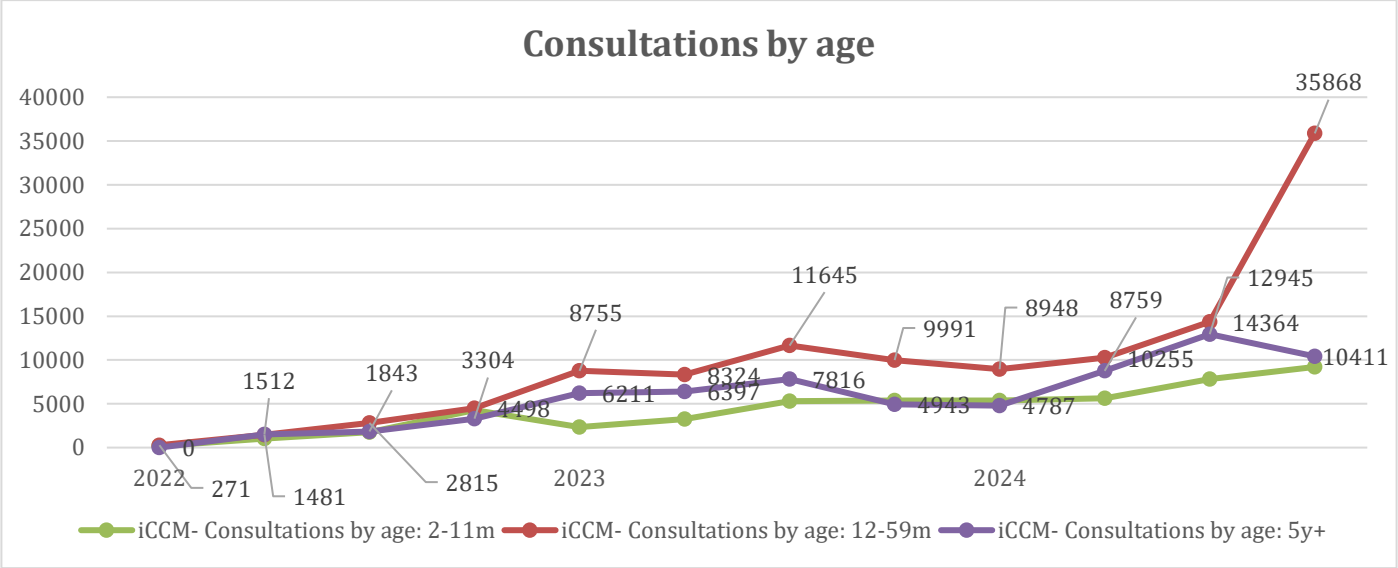


The data show a substantial rise in new consultations from 2022 through 2024, indicating a significant expansion of service delivery. Consultation volumes grew dramatically over this period, for example, starting at 449 new consultations at the beginning of 2022 and reaching 8,742 by the end of 2022. This volume continued its rapid ascent, climbing to a peak of 58,497 by the final data point in 2024. This sharp increase can be understood considering the launch of iCCM activities at the new Cibitoke site and the increase in the number of consultations at the Yei site, potentially due to intensified demand creation activities (awareness raising, education, and communication).

11.2 Consultations (by age group)

This indicator measures the total number of consultations provided to children by age group (2 to 11 months, 12 to 59 months, and 5 years or older). The graphic shows the number of consultations for each age group during the reporting period.

Figure 2 Number (n) of iCCM consultations in OCB by age group, 2022-2024



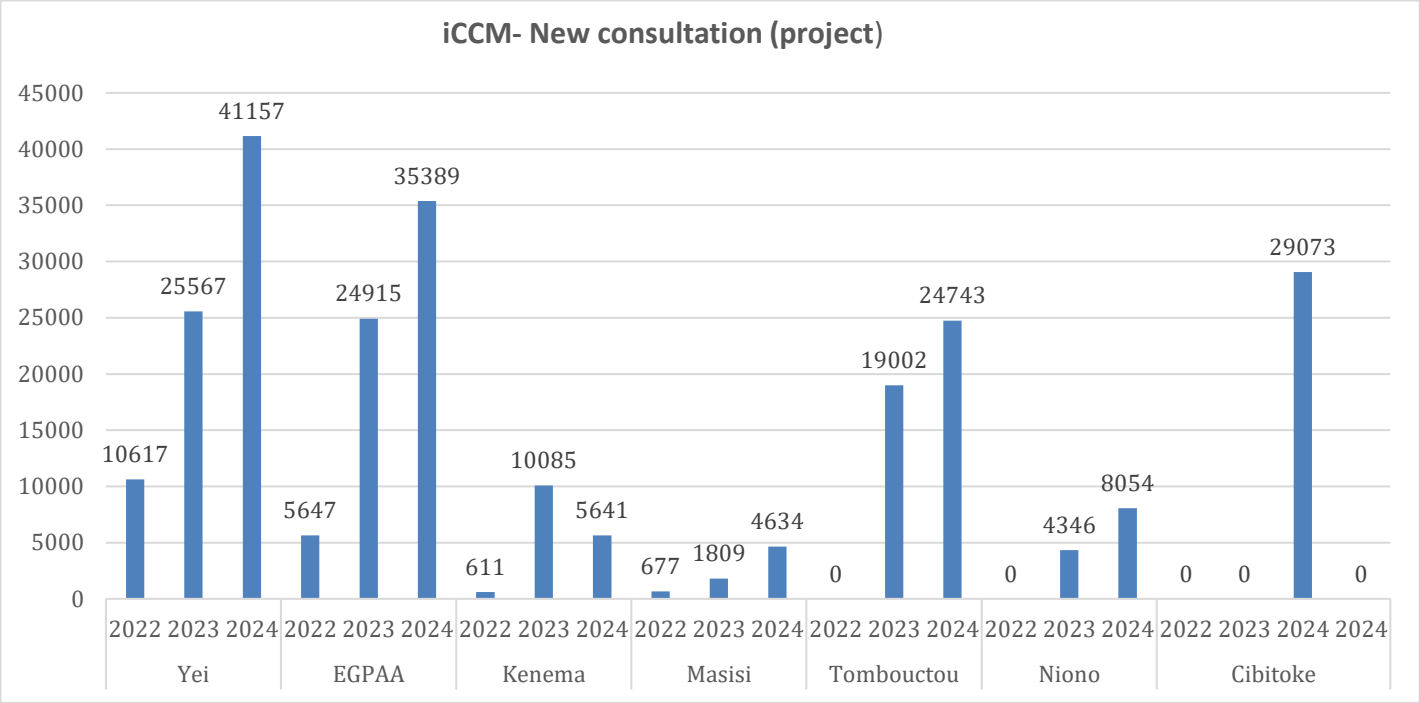
As illustrated in the graph above, the 12- to 59-month age group accounted for the largest share of consultations throughout the observation period. This age group saw a sharp increase in consultations, particularly in the final observed period (2024), peaking at 35,868. Overall, this increase in consultations suggests an improvement in uptake of and demand for iCCM, with a gradual broadening of the demographic scope over time.

Analysis by project sites

Across all project sites, community health consultations increased steadily between 2022 and 2024, indicating a positive trend in service uptake and demand for iCCM. However, the intensity and structure of consultations varied widely by site.

11.3 New iCCM Consultations

Figure 3 Number (n) of new iCCM consultations by project, 2022-2024

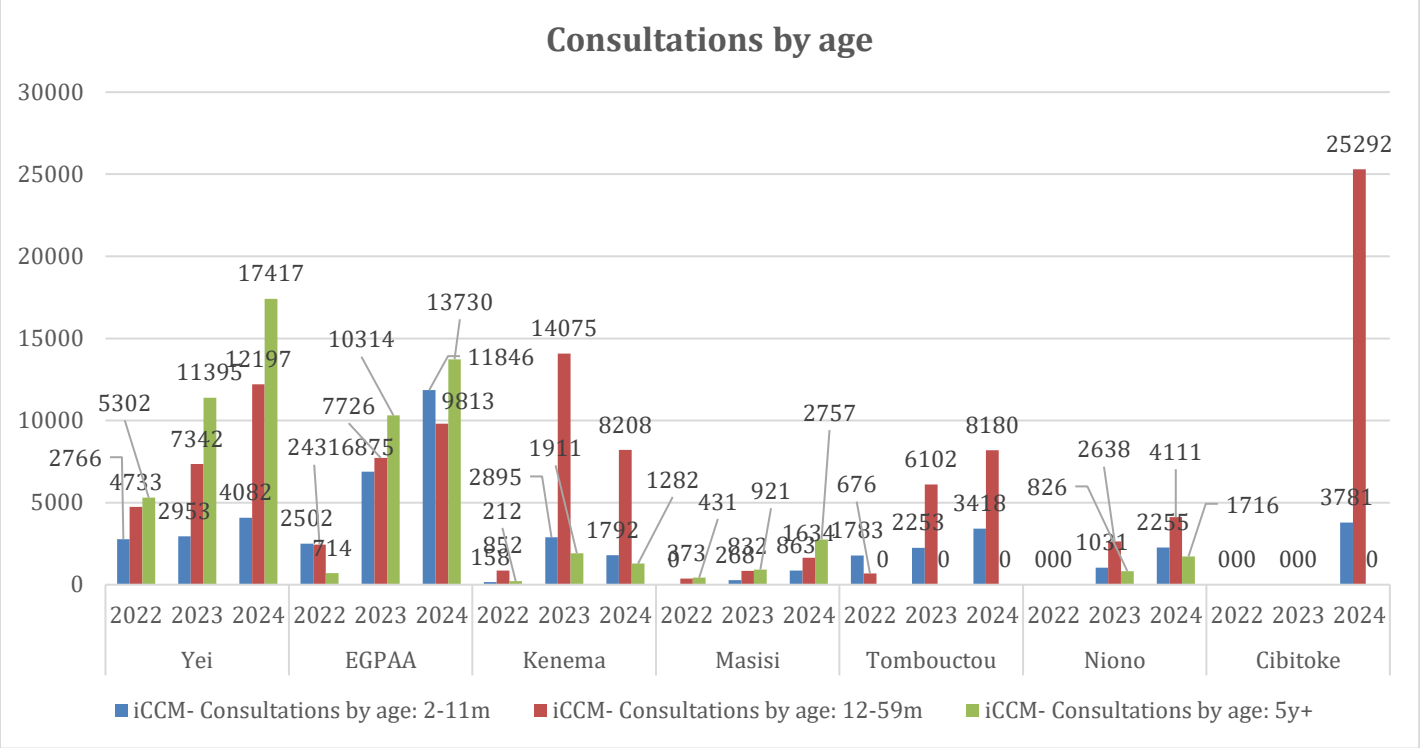


This indicator tracks the total number of new consultations conducted by CHWs under the project, reflecting the project's reach and community engagement in addressing childhood illnesses such as malaria, diarrhoea, and pneumonia.

The trend in new consultations mirrored these patterns. EGPAA saw a steep rise in new cases, with year-on-year increases of up to 40%, while Tombouctou remained relatively flat, with no major fluctuations. EGPAA also showed strong growth in new consultations throughout the period under evaluation (2022-2024). In summary, the consultations indicator shows that EGPAA and Yei (South Sudan) and Cibitoke (Burundi) are driving the overall increase in service coverage, while Masisi and Niono (DRC and Mali) continue to reflect limited outreach or under-use. Yei (South Sudan) consistently reported the highest number of consultations, reaching more than 24,000 new consultations in 2023 alone and maintaining high levels in 2024.

11.4 Consultations (by age group and project)

Figure 4 Number (n) of iCCM consultations by age group and by project, 2022-2024



Overall, the data shows a consistent increase in iCCM consultations across most sites between 2022 and 2024. This may reflect strengthened community health worker activities and improved access to care. This upward trend was particularly evident in Yei and EGPAA, where consultation volumes more than doubled (from 4,736 to 17,417 and from 7,726 to 13,730, respectively) among children 5 years and over. The sharp rise in consultations among this age group (17,417 in Yei and 13,730 in EGPAA) suggests an expansion of services beyond those under 5 years old, or a resurgence of community-level febrile illnesses affecting older populations.

Kenema follows the opposite trajectory with the intermediate age group (12–59 months), going from a high performance (14.075) in 2023 to a performance almost half that in 2024 (8.208), suggesting a potential decline in CHW performance in their activities. In contrast, Timbuktu and Niono start from almost 0 in 2022 and achieve higher performance in the following two consecutive years for both the youngest (2–11 months) and middle (12–59 months) age groups. This is likely due to an increased presence of CHWs and broader geographic coverage.

Cibitoke is an exceptional case: consultations surged dramatically to 25,292 in 2024 (12–59), including 3,781 in the 2–11 months age group.

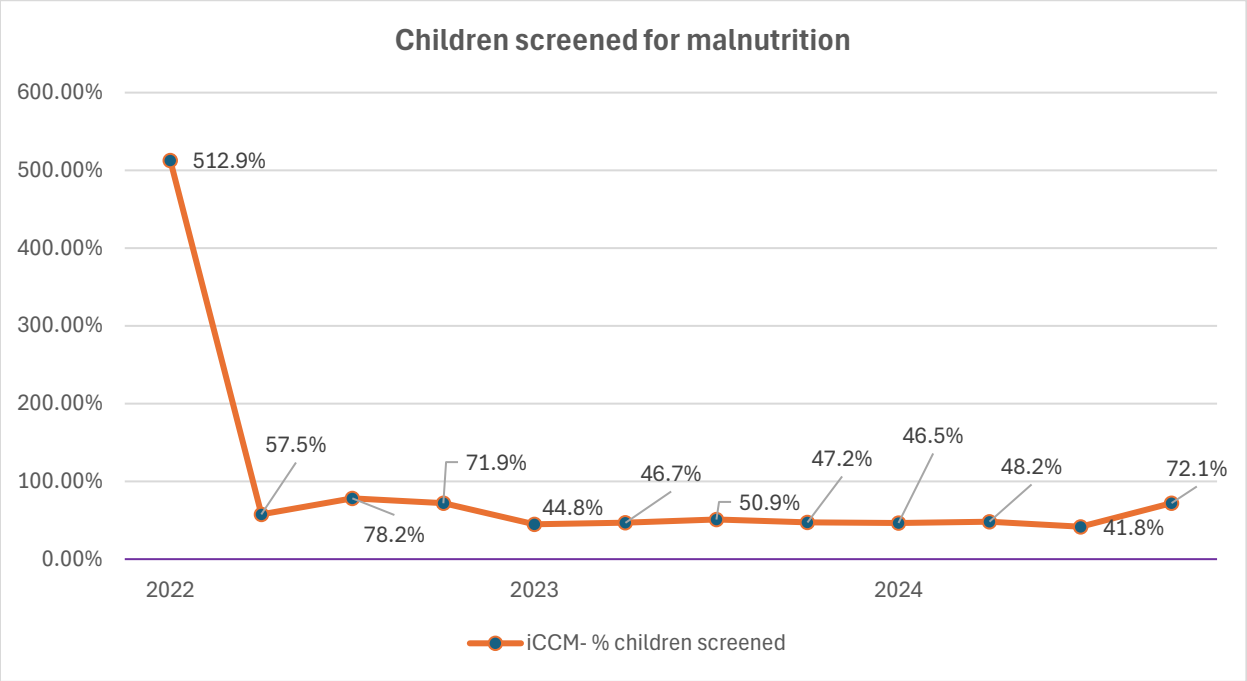
The year 2024 marks a significant rebound in the number of consultations, probably linked to better CHW deployment and the strengthening of the supervision system, but even more so to the start of operations at the Cibitoke site, with particularly strong performance among children 12-59 months.

However, significant disparities between sites (from ~2,000 to over 25,000 cases) highlight the lack of uniformity in site maturity and implementation contexts across different operational areas.

11.5 Malnutrition (MUAC screening coverage)

The figure below shows the proportion of children screened for malnutrition out of all new consultations. The numerator is the number of children screened, and the denominator is the total number of new consultations.

Figure 5 Percentage (%) of children screened for malnutrition during iCCM activities in OCB, 2022-2024



The proportion of children screened for malnutrition showed significant volatility in the initial phase. It registered an anomalous peak at 512.9% in 2022 (likely indicating a data anomaly or a period where screening efforts vastly outnumbered consultations), before stabilizing at approximately 60% to 80% throughout the rest of that year.

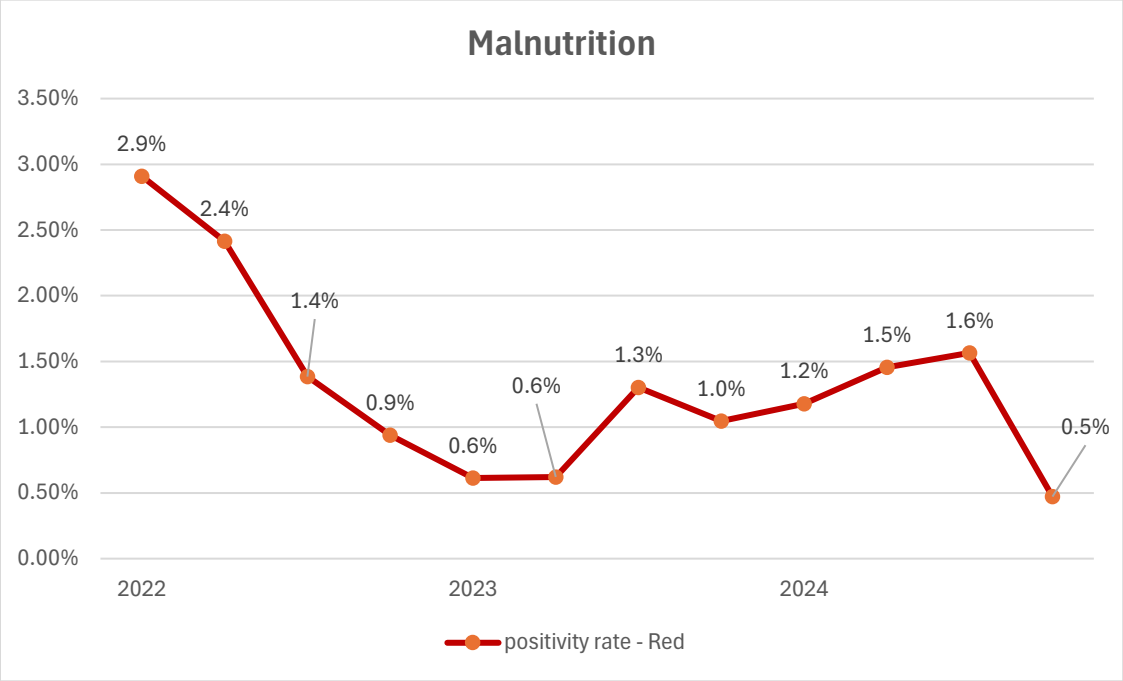
Subsequently, the screening coverage was integrated more consistently into routine consultations, averaging close to 50% in 2023 (with the lowest point at 44.8%).

In 2024, screening coverage remained relatively stable, fluctuating between 46.54% and 72.01%. While the coverage did not drop below 40% as suggested previously, this moderate fluctuation (approximately 9 percentage points) highlights ongoing minor inconsistencies in routine screening practices, which may be influenced by resource gaps or seasonal programmatic factors.

11.6 Malnutrition (Positive rate: severity)

This indicator measures the proportion of screened children whose MUAC falls in the red category, indicating SAM. The numerator is the number of children with red MUAC, and the denominator is the total number of children screened.

Figure 6 Percentage (%) of children identified with severe malnutrition during iCCM activities in OCB, 2022-2024

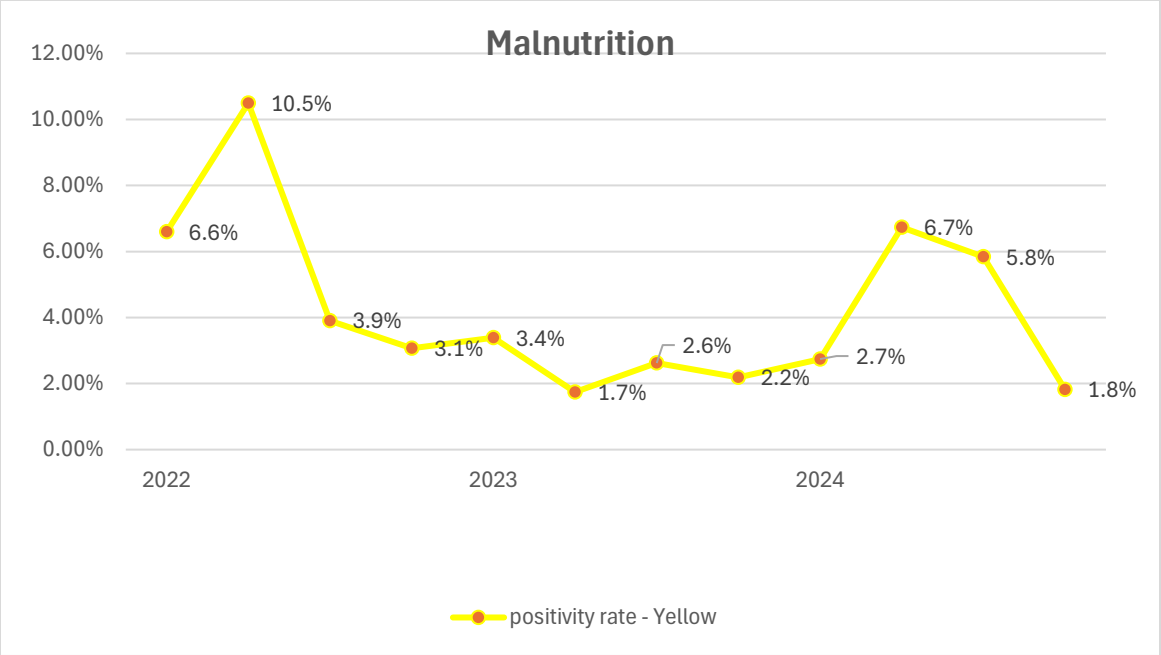


The positivity rate (Red MUAC, indicating SAM) among screened children is systematically very low during the 2022-2024 period. The observed rates fall within a very narrow range, from a minimum of 0.5% to a maximum of 2.9%. This low screening yield (below 3%) suggests that the prevalence of SAM is low in the general population or intervention area.

11.7 Malnutrition (Moderate Acute Malnutrition)

This indicator measures the proportion of screened children whose MUAC is in the yellow category, indicating moderate acute malnutrition. The numerator is the number of children with yellow MUAC, and the denominator is the total number screened.

Figure 7 Percentage (%) of children identified with moderate malnutrition during iCCM activities in OCB, 2022-2024



Contradicting the assumption of an initial sharp increase followed by a steady decline, the positivity rate for moderate malnutrition (yellow MUAC) showed high volatility between 2022 and 2024.The rate first peaked at 10.5% in 2022. It then fell dramatically and remained low throughout 2023, ranging from a minimum of 1.7% to a maximum of 3.9%. In 2024, however, the trend reversed, reaching a second peak of 6.7% before falling back to 1.8% by the end of the period.

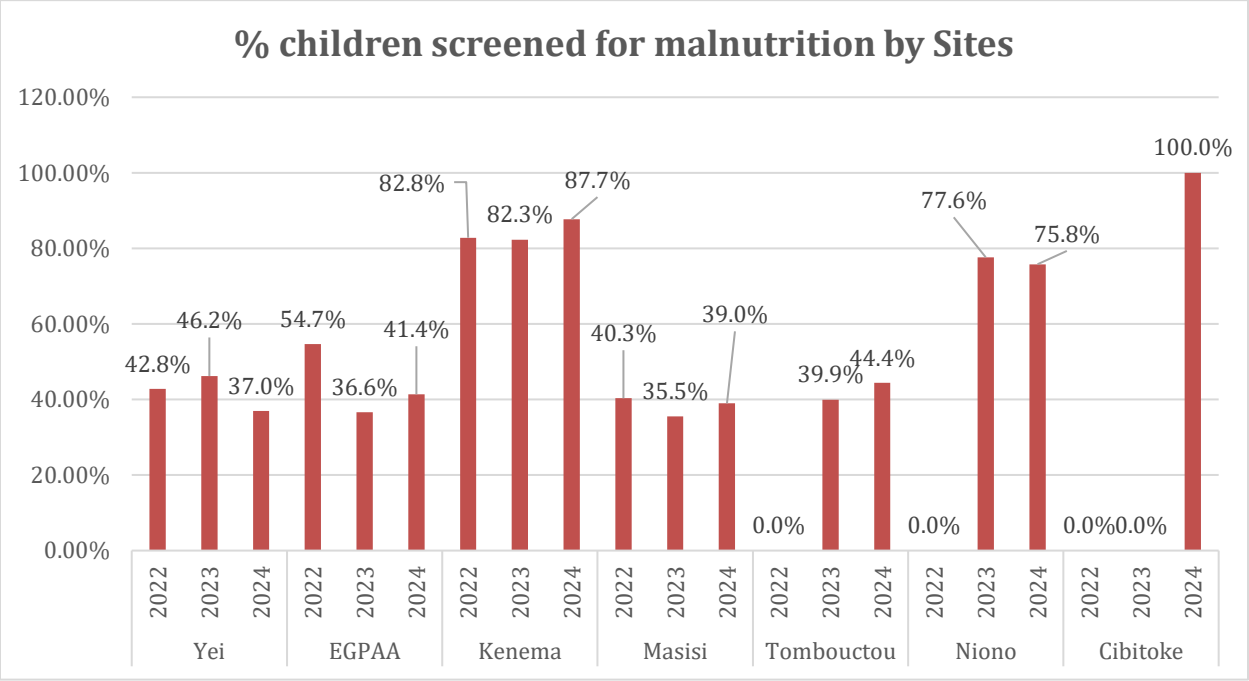
These trends imply operational or epidemiological instability in the detection of moderate cases of malnutrition. This variability suggests that the proportion of moderately malnourished children identified is highly sensitive to environmental factors and screening periods. The final decline to 1.8% may reflect an improvement in nutritional status or simply expanded screening of healthy children.

Malnutrition analysis by projects

Trends in moderate malnutrition reveal significant fluctuations in detection rates. These variations, although not directly related to coverage, confirm a worrying situation regarding the regularity of screening and the need for a stable nutrition intervention. The data reinforce the critical need for sustainable integration of nutrition into iCCM services.

11.8 Malnutrition (MUAC screening coverage)

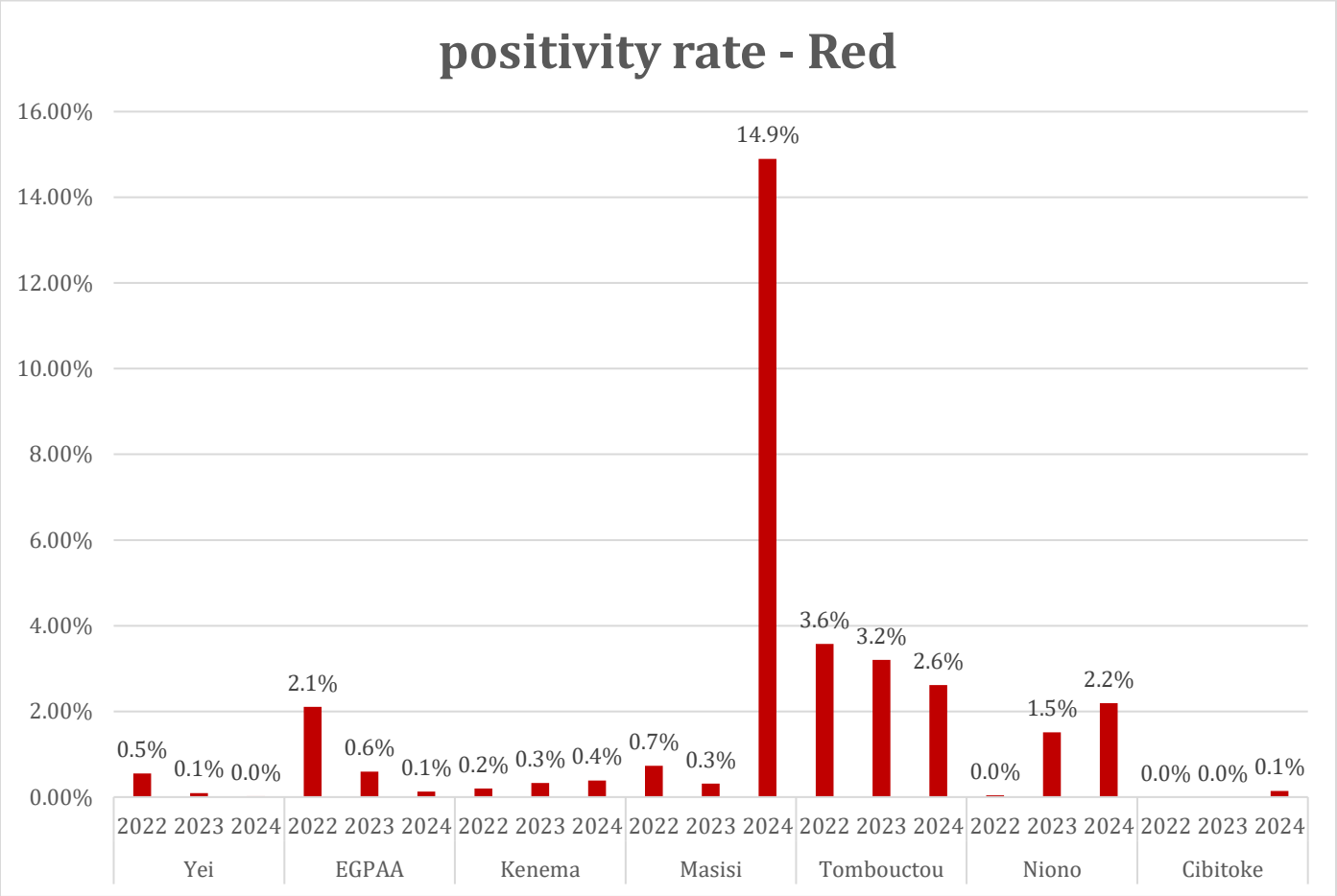
Figure 8 Percentage (%) of children screened for malnutrition during iCCM activities by project, 2022-2024



Across the various sites and years, the proportion of children screened for malnutrition under iCCM activities shows both progress and fluctuation. For example, in Yei (South Sudan), the screening rate improved from 42.8% in 2022 to 46.2% in 2023, but declined to 37% in 2024, indicating possible operational or outreach challenges in sustaining high coverage. Conversely, in Kenema (Sierra Leone), rates remained consistently high, above 82%, reflecting robust implementation. Notably, Cibitoke (Burundi) reported 100% screening coverage in 2024, suggesting either excellent performance or potential over-reporting. This disparity suggests that while some CHWs have effectively mainstreamed nutritional screening into consultations, others may lack tools, training, or time.

11.9 Malnutrition (Severe Acute Malnutrition, Red MUAC)

Figure 9 Percentage (%) of children identified with severe malnutrition during iCCM activities by project, 2022-2024



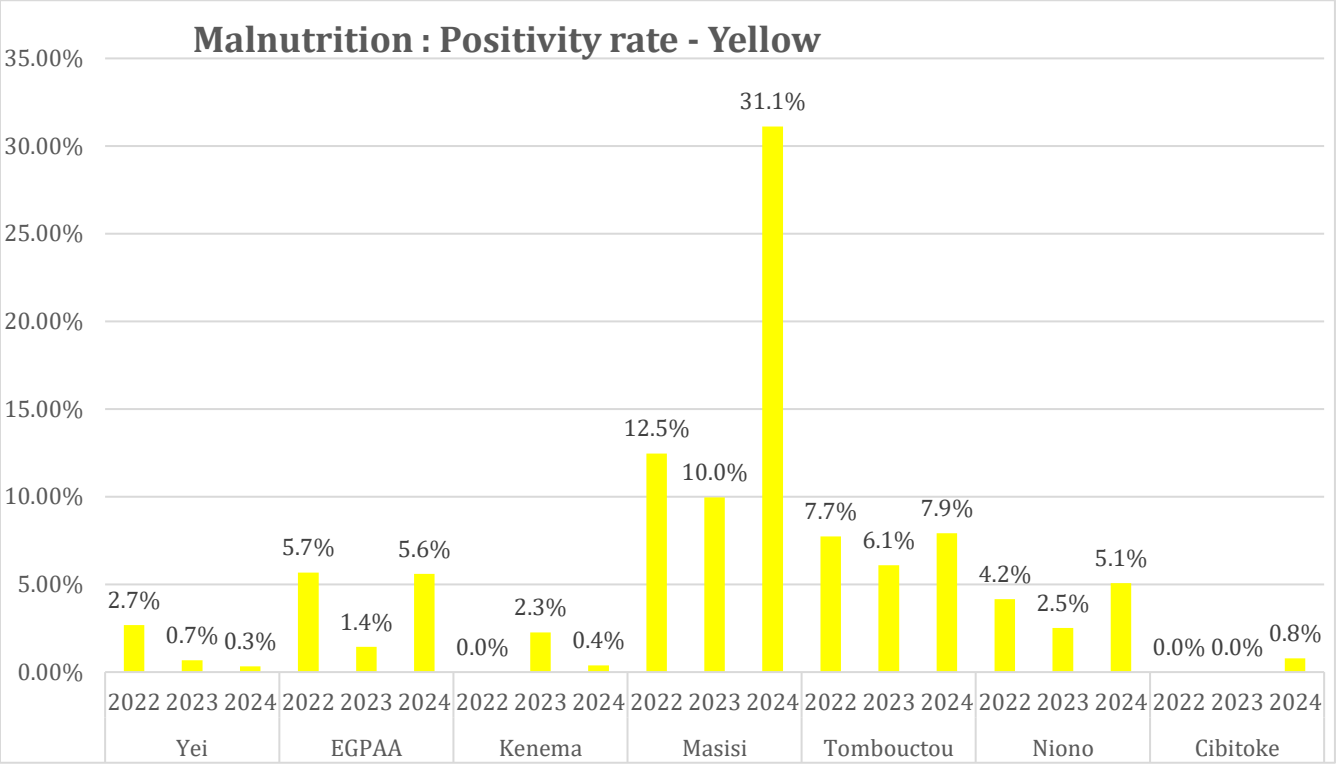
Although most sites show relatively low rates (below 4%), Masisi, exceptionally, recorded a peak of 14.9% in 2022.

The proportion of children identified with SAM (Red MUAC) remained low across most sites. For instance, Yei (South Sudan) recorded a positivity rate of 0.5% and 0.1% respectively in 2022 and 2023, dropping to 0% in 2024. EGPAA, had a higher baseline of 2.1% in 2022, decreasing to 0.1% by 2024. Similarly, Cibitoke's severe malnutrition is very low (0.1%) in 2024. These trends suggest either a true reduction in malnutrition severity or changes in case detection and data reporting.

Kenema maintained relatively stable low rates, below 0.5%, while Tombouctou presented a gradual decline from 3.5% in 2022 to 2.6% in 2024, suggesting either a real reduction or under-detection. While these figures are encouraging, they must be interpreted with caution given potential limitations in screening coverage and data quality.

11.10 Malnutrition (Moderate Acute Malnutrition, Yellow MUAC)

Figure 10 Percentage (%) of children identified with moderate malnutrition during iCCM activities by project, 2022-2024



Moderate malnutrition (Yellow MUAC) rates were notably higher than severe cases across all sites. Masisi recorded persistently high rates during the three years: 12.4% in 2022, 10% in 2023, and 31% in 2024, indicating ongoing food insecurity or health system gaps in prevention and treatment.

Tombouctou (Mali) also had high moderate malnutrition rates, almost stable throughout the years: approximately 8% in 2022, while the rate in Niono (Mali) rose from 2.5% in 2023 to 5.1% in 2024, suggesting rising vulnerability or improved detection.

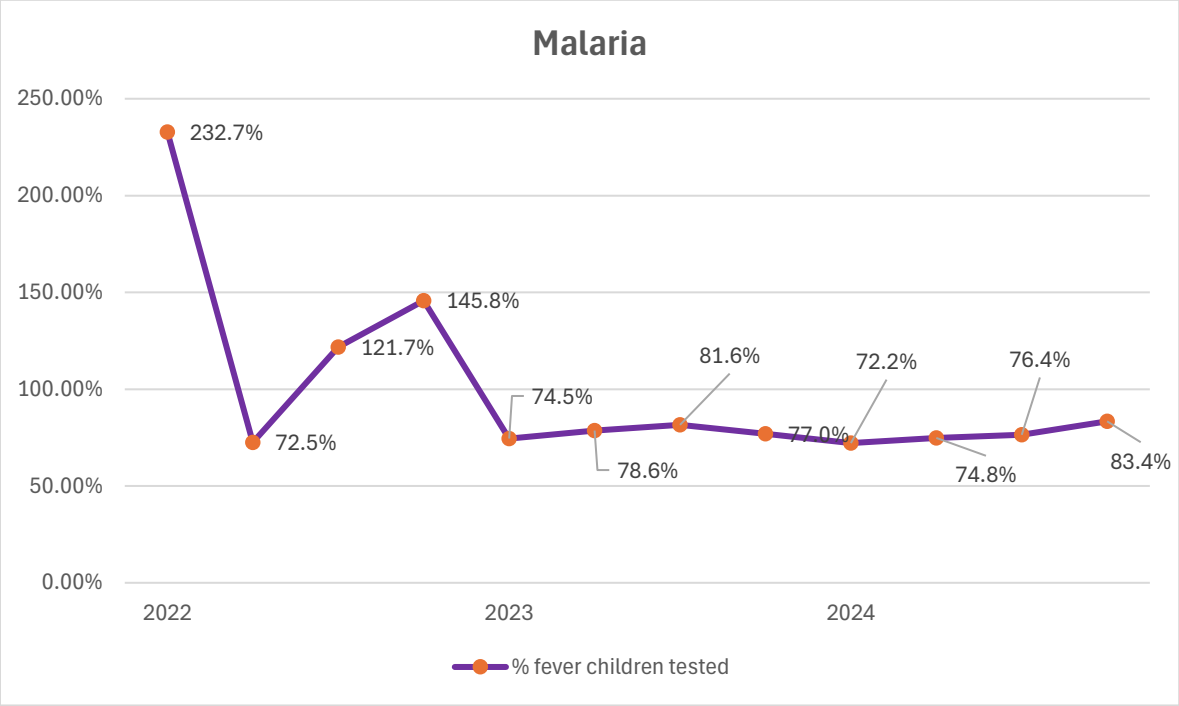
Kenema (Sierra Leone) demonstrated moderate and decreasing rates: 2.3% (2023) to 0.4% (2024), potentially reflecting the impact of strengthened nutrition interventions. Yei's trend dropped from 2.7% in 2023 to 0.3% in 2024, while EGPAA showed fluctuating but declining figures: 5.7% in 2022, 1.4% in 2023, then 5.6% in 2024, suggesting inconsistent service delivery or data quality.

These trends point to a need for reinforced multi-sectoral nutrition strategies in sites like Masisi, Tombouctou, and Niono, where moderate malnutrition remains a public health concern.

11.11 Malaria (% fever cases tested)

This indicator is the proportion of children with fever who were tested for malaria. The numerator is the number of fever cases tested positive in addition to those tested negative (RDTs performed), and the denominator is the total number of new consultations with fever symptoms. For project sites analysis, values from Tombouctou and Niono for the year 2022 were missing.

Figure 11 Percentage (%) of febrile children tested for malaria during iCCM activities in OCB, 2022-2024



An analysis of quarterly data from 2022 to 2024 concerning the proportion of febrile children tested for malaria reveals high initial volatility, followed by stabilisation at a high level.

The year 2022 is characterised by notable reporting anomalies. Testing coverage reached an exceptional peak of 232.7% in Q1, followed by a sharp drop to 72.5% in Q2. Rates then climbed back above 100% (121.7% and 145.8%) in Q3 and Q4. These figures exceeding the 100% threshold suggest significant issues with data quality or reporting errors, or a mismatch between the numerator (tests performed) and the denominator (new consultations).

From 2023 onwards, the rates stabilised within a higher but more realistic range, fluctuating between 74.5% and 81.6%. This period indicates strengthened adherence to integrated community case management (iCCM) protocols and consistent operational capacity. Quarterly rates remained strong, reflecting improved capacity among CHWs and acceptable availability of RDTs.

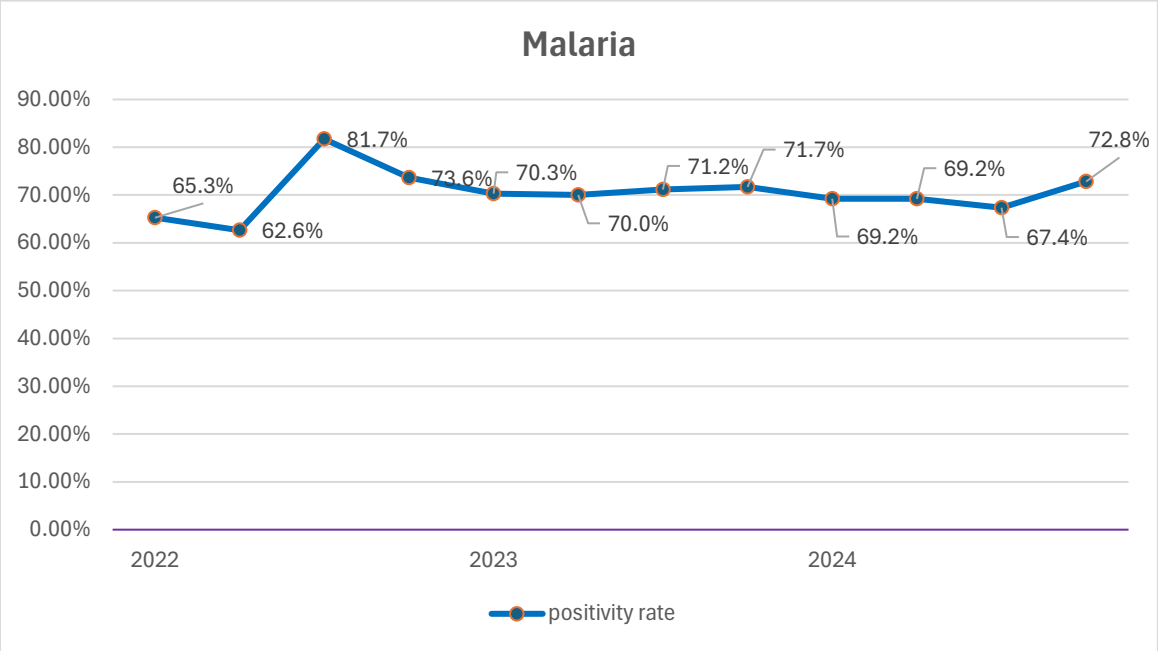
This trend continued into 2024, with rates ranging from 72.2% to 83.4%. The final quarter recorded the highest testing rate of the post-anomaly period. Although there is persistent quarterly variability, coverage remains solidly above 70%.

In conclusion, while the 2023–2024 period demonstrates a consistently high level of protocol compliance, the extremes observed in 2022 require an immediate investigation into the collection and reporting methodology to ensure the reliability of the indicators. To consolidate these gains, continued support for supply chain stability and regular supervision is essential.

11.12 Malaria (% Positive Cases)

This measures the percentage of malaria tests that returned positive results. The numerator is the number of positive tests, and the denominator is the total number of malaria tests conducted.

Figure 12 Percentage (%) of malaria positive cases among those tested during iCCM activities in OCB, 2022-2024



The malaria positivity rate remained extremely high and persistent throughout the period from 2022 to 2024, confirming that malaria is still a significant cause of fever within the community. The rate consistently remained above 60%, often exceeding 70%.

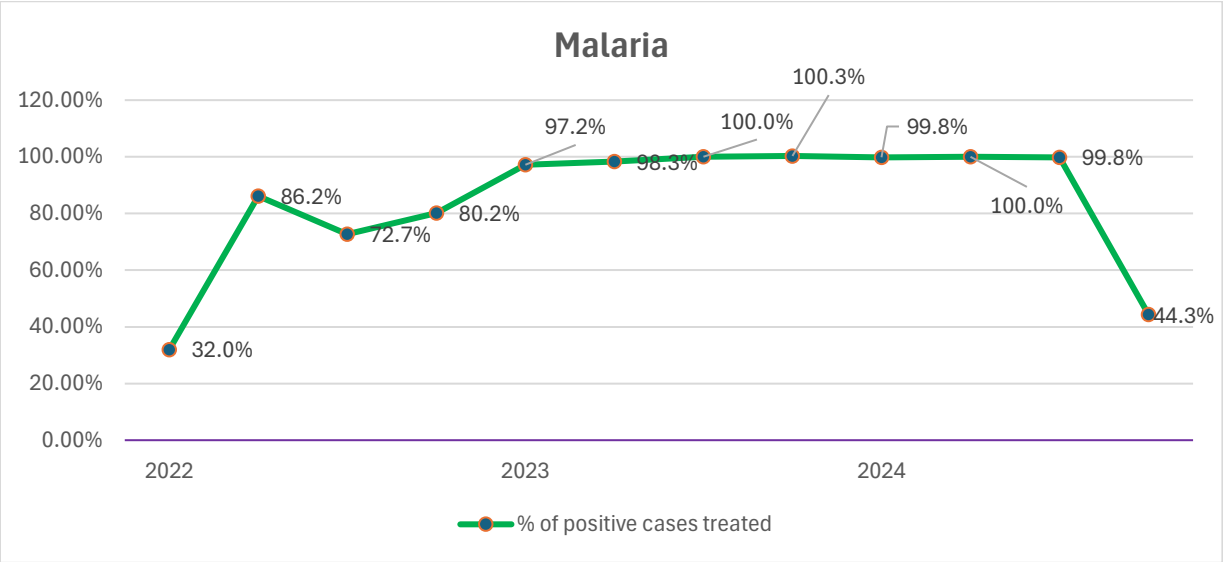
2022 was a year of high volatility. After starting at 65.3%, it briefly dropped to 62.6% before reaching a significant peak of 81.7% in Q3, then decreasing toward the end of the year. In 2023 the positivity rate stabilised within a very high range, fluctuating narrowly between 70.3% and 71.7%. In 2024, following a slight mid-year decrease to around 67.4%, the period concluded with a notable increase to 72.8%.

This trend highlights sustained disease burden and shows that there was no significant reduction in malaria prevalence over these three years.

11.13 Malaria (% Positive Cases Treated)

This indicator is the proportion of confirmed positive malaria cases that received treatment. The numerator is the number of positive cases treated, and the denominator is the total number of confirmed positive cases.

Figure 13 Percentage (%) of children treated for malaria among those tested positive during iCCM activities in OCB, 2022-2024



The percentage of malaria cases that were treated with the correct therapy reached near-optimal levels from 2023 onwards. By the end of 2022, over two-thirds (72.7%) of positive cases were being treated. This metric increased steadily throughout 2023, rising from 80.2% to reach and maintain optimal levels (between 97% and 100%). This reflects excellent access to case management and the good availability of essential malaria commodities during that period.

Most notably, the project succeeded in maintaining near-perfect treatment coverage throughout 2024, with treatment rates consistently reaching 100% (e.g. 99.8%). This suggests that project activities continued to effectively ensure access to treatment.

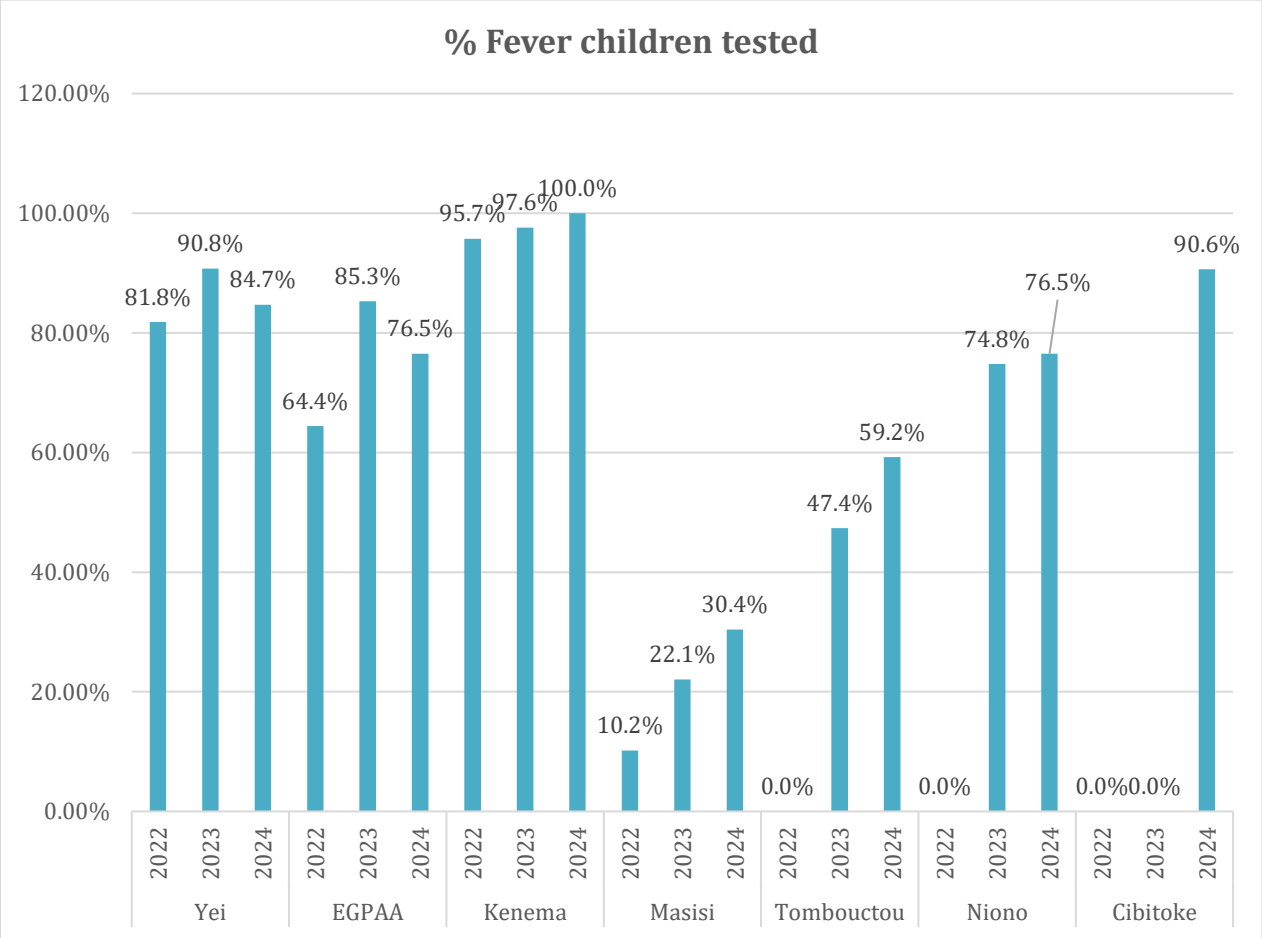
However, therapeutic coverage experienced a drastic and sudden drop at the end of the observed period, with the proportion of positive cases treated falling sharply to 44.3%. This decline did not occur in the middle of 2024, but highlights sudden operational challenges, such as drug stock-outs or supply chain interruptions, that temporarily and severely impeded treatment delivery at the end of the project cycle.

The project's capacity to test and treat cases was exceptionally strong in 2023 and 2024. The sudden plunge to 44.3% at the end of the period underscores the critical need for sustained support and early warning systems to prevent future service disruptions and maintain the high level of treatment coverage achieved.

Fever tested and treated, case analysis by project sites

11.14 % of Fever Cases Tested

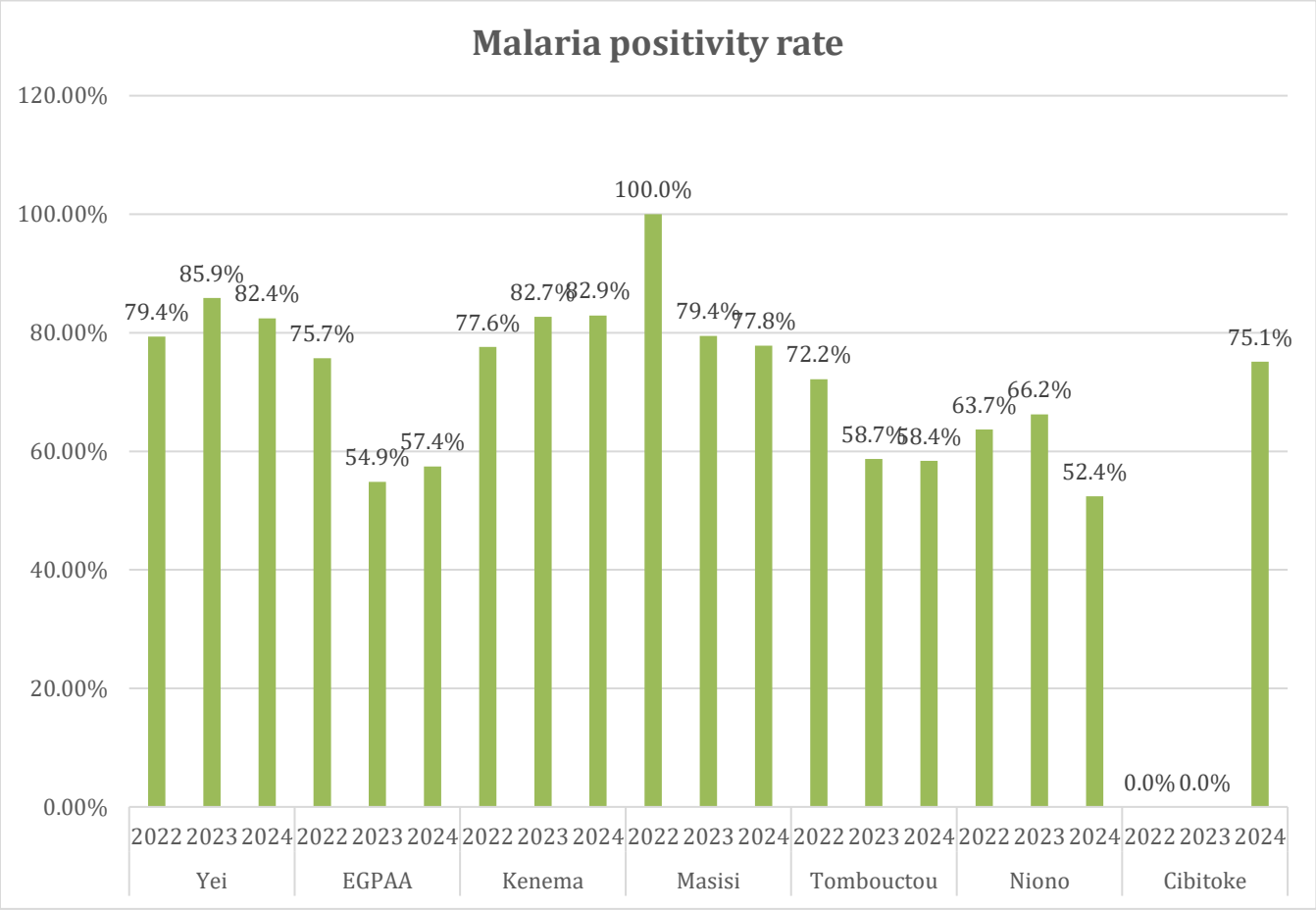
Figure 14 Percentage (%) of febrile children tested for malaria during iCCM activities by project, 2022-2024



Although data on this specific metric was limited or inconsistently reported, the available figures confirm that Kenema (with rates consistently above 95% over the three years) and Yei (ranging from approximately 81% to 90%) maintained strong diagnostic coverage, regularly testing over 80% of children with fever. Furthermore, Cibitoke and EGPAA also exceeded 85% testing in 2024. Sites with weaker testing performance, such as Masisi (consistently below 30%) and Tombouctou (never above 60%), risk missing confirmed cases or incorrectly performing presumptive treatment, which is not recommended.

11.15 Malaria Positivity Rate

Figure 15 Percentage (%) of malaria positive cases among those tested during iCCM activities by project, 2022-2024



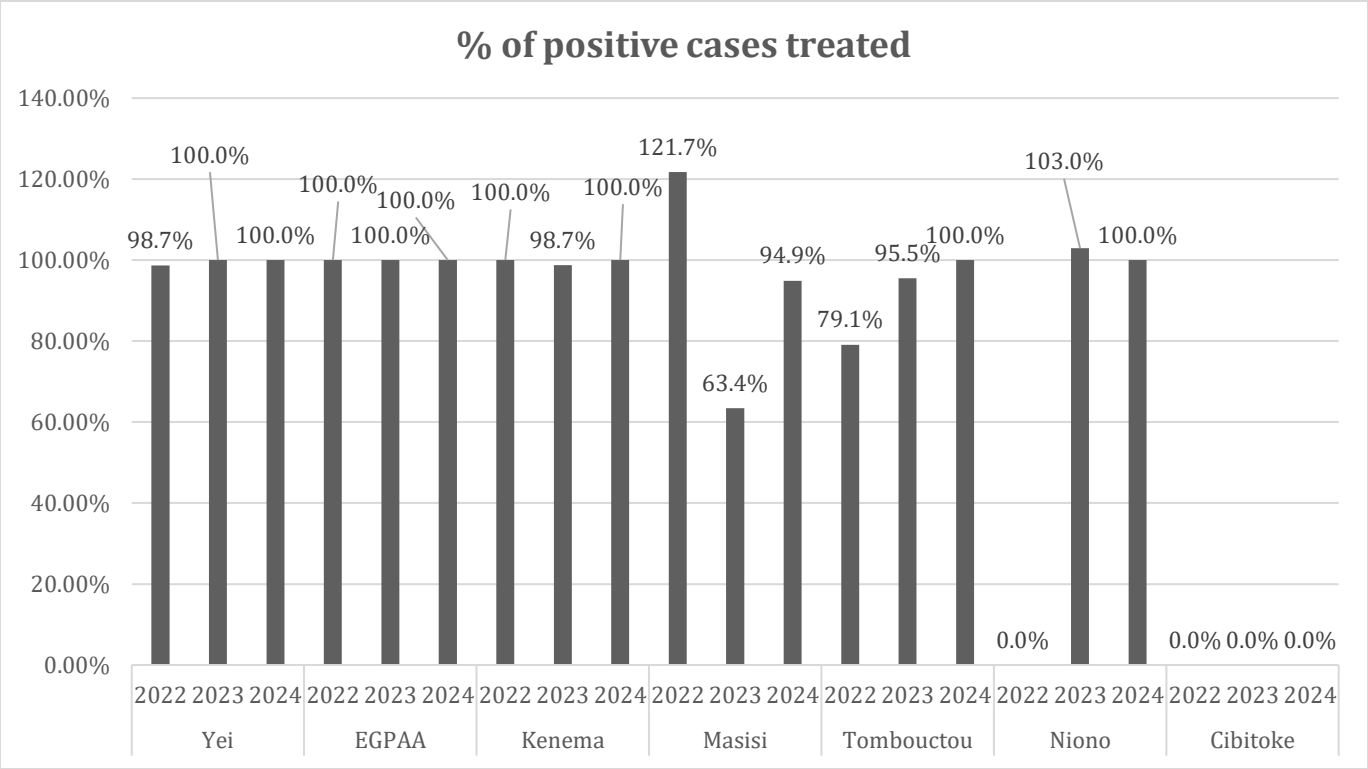
Across most sites, malaria positivity remained consistently high, confirming malaria as a leading cause of febrile illness in children under five.

Yei and Kenema reported high positivity rates, throughout the three-year period, often exceeding 75%. Cibitoke (2024) and EGPAA (2022) followed closely, with positivity rates at 75%. In contrast, EGPAA and Tombouctou in 2023 and 2024 recorded notably lower malaria positivity rates, dropping below 60%, which may reflect either lower transmission or possible under-testing.

The overall trend shows (Yei, Kenema, Masisi, Cibitoke) remained with high burden, while others (Tombouctou, EGPAA) saw more fluctuation or potentially declining malaria transmission.

11.16 % of Positive Cases Treated

Figure 16 Percentage (%) of children treated for malaria among those tested positive during iCCM activities by project, 2022-2024



The treatment coverage of malaria-positive cases varied considerably by site and over time. EGPAA, Yei, and Kenema achieved consistently high treatment rates of 95–100% in most quarters, reflecting strong case management systems and medicine availability.

However, it is important to note that the reported coverage figures for Masisi in 2022 and Niono in 2023 technically exceeded 100% respectively in 2022 and 2023. As coverage cannot exceed 100%, this suggests inconsistencies in data reported.

Masisi however, showed the lowest treatment performance in 2023, with less than 65%, before rebounding in 2024 (95%). Tombouctou is starting from a coverage of 79% of cases treated in 2022 for a performance level where all malaria cases detected have been treated, 100% coverage in 2024, which denotes effective management.

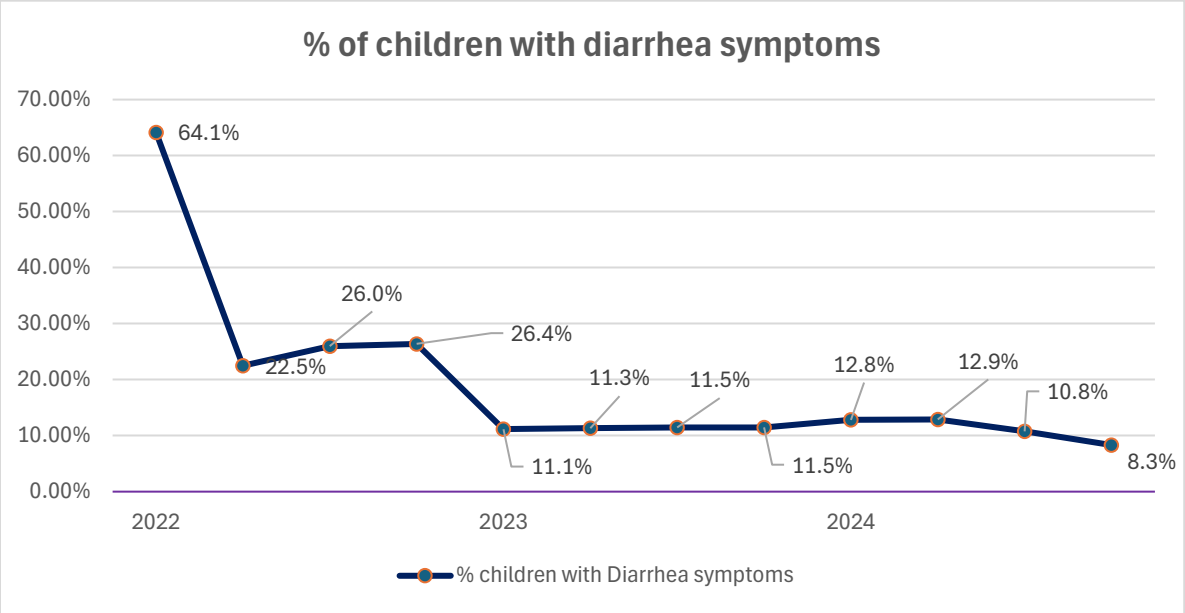
These trends highlight the success of Yei, EGPAA, and Kenema in ensuring treatment after diagnosis, while also revealing persistent gaps in the DRC (Masisi).

In summary, malaria remains a major challenge across all sites and there is considerable consistency between testing and treatment.

11.17 Diarrhoea Cases

This measures the proportion of new consultations for children presenting diarrhoea symptoms. The numerator is the number of diarrhoea cases, and the denominator is the total number of new consultations.

Figure 17 Percentage (%) of children identified with diarrhoea during iCCM activities in OCB, 2022-2024



Between 2022 and 2024, there was a dramatic decline in the proportion of children presenting with diarrhoea symptoms, falling from a peak of 64.1% in early 2022 to 8.3% by the end of 2024.

This trend manifested as an initial massive drop in 2022 (reaching 22.5%), followed by a brief stabilisation period around 26%. A second significant decrease occurred at the beginning of 2023 (around 11.1%), leading to a long period of stabilisation with minimal fluctuations (between 11.14% and 11.5%). In early 2024, there was a slight recovery (up to 12.8%), before the rate resumed its downward trend, reaching a low of 8.3%.

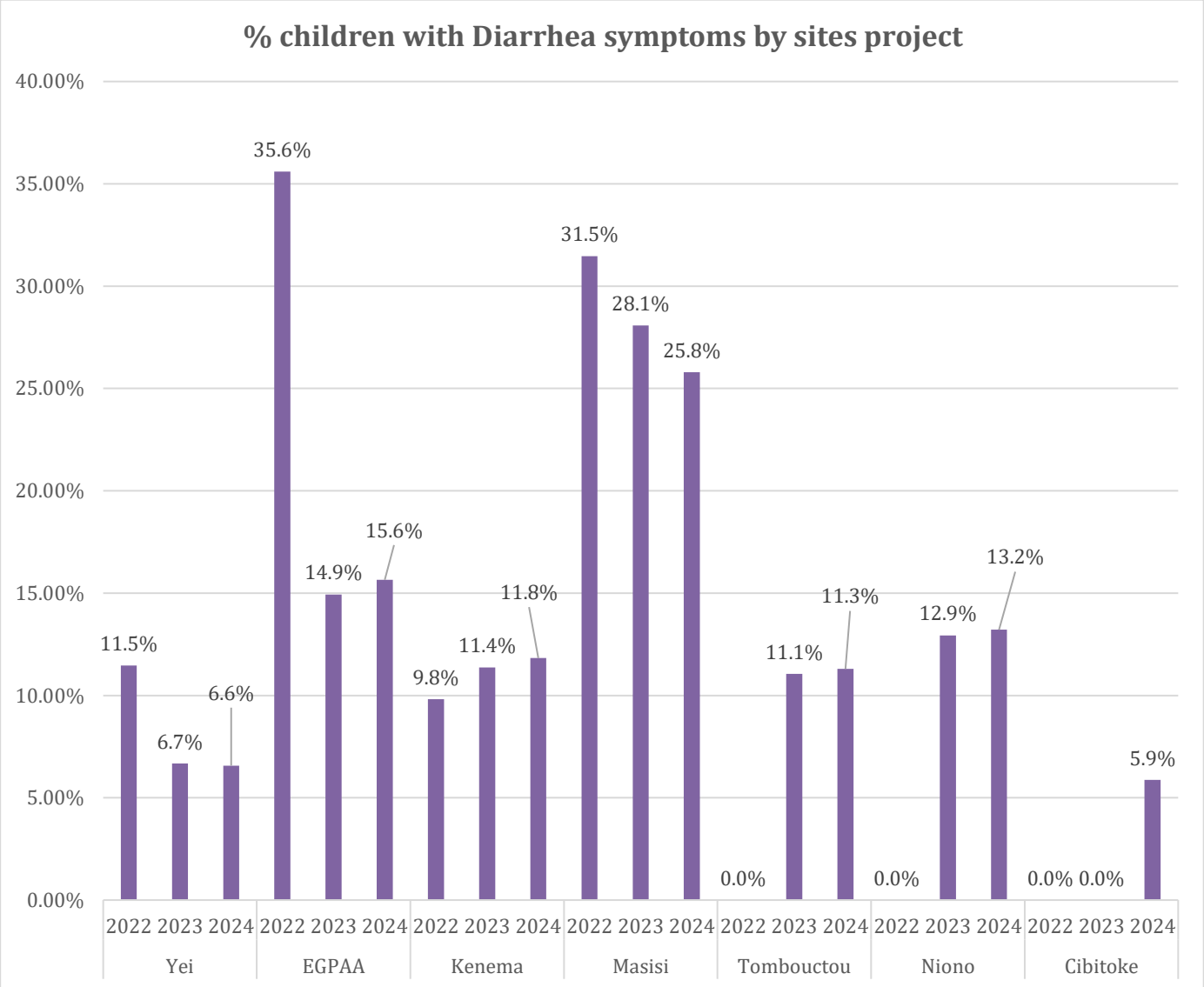
This step-like pattern, characterised by phases of rapid decline and stabilisation plateaus, may reflect seasonal dynamics, the initial impact and progressive effectiveness of water, sanitation and hygiene (WASH) interventions, or changes in care-seeking behaviour and reporting.

Continued surveillance and more granular analysis are necessary to determine whether these changes signal a true and sustained reduction in the diarrhoea burden, or whether they are influenced by potential under-reporting or variability in project activities.

11.18 Diarrhoea cases project sites

The indicator tracking the percentage of children presenting with diarrhoea symptoms reveals a worrying but uneven burden across project sites.

Figure 18 Percentage (%) of children identified with diarrhoea during iCCM activities by project, 2022-2024



Analysis of diarrhoea symptom prevalence among children reveals that EGPAA and Masisi are the most affected areas. EGPAA recorded the highest peak in 2022, reaching 35.6%, before experiencing a significant drop of around 15% in 2023 and 2024. Masisi, on the other hand, had a consistently high prevalence of diarrhoea over the three years, with rates ranging from 25.8% to 31.5%. This persistent high prevalence is a key indicator of major challenges relating to WASH conditions and access to preventive care.

Kenema (9% to 12%) and, to a lesser extent, Tombouctou and Niono show moderate levels of diarrhoea symptoms. Notably, Tombouctou and Niono showed moderate peaks (up to 13.2% in Niono) in 2023 and 2024, indicating variability. This variability could indicate seasonal epidemics or temporary infrastructure gaps.

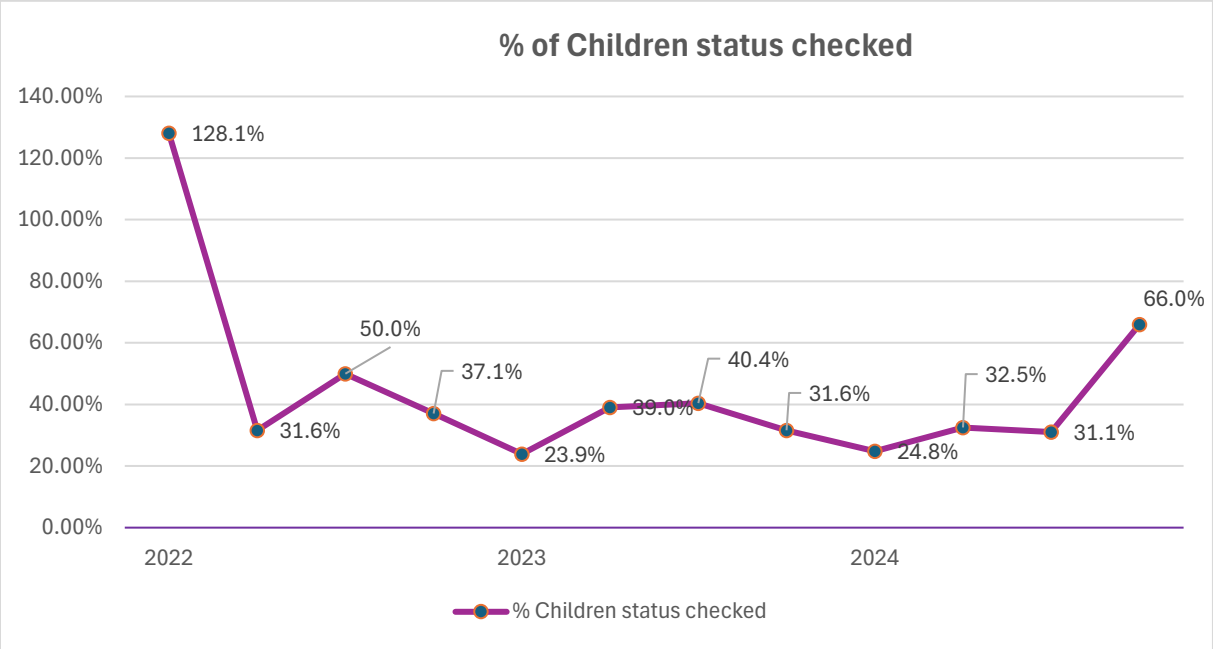
Yei and Cibitoke also exhibited low rates (below an average of 10%), with Yei ranging from 6 to 11%, and Cibitoke reporting a single peak of 5.9% in 2024. These results suggest more favourable basic health and hygiene conditions.

In summary, the diarrhoea indicator highlights significant disparities between sites, reinforcing the need to integrate WASH interventions, nutrition programmes and CHW capacity building. Specific efforts must target sites with consistently high prevalence, such as Masisi, and sites experiencing irregular peaks, such as EGPAA and Niono, to address not only case detection, but also the underlying determinants of diarrhoeal disease.

11.19 Immunisation (% children status checked)

It should be noted that missing data occur for EGPAA (2022–2024) and Masisi 2022, as well as for Kebbi (2022–2024).

Figure 19 Percentage (%) of children screened for immunisation status during iCCM activities in OCB, 2022-2024



The chart above, illustrates the significant volatility in the proportion of children whose vaccination status was verified between 2022 and 2024.

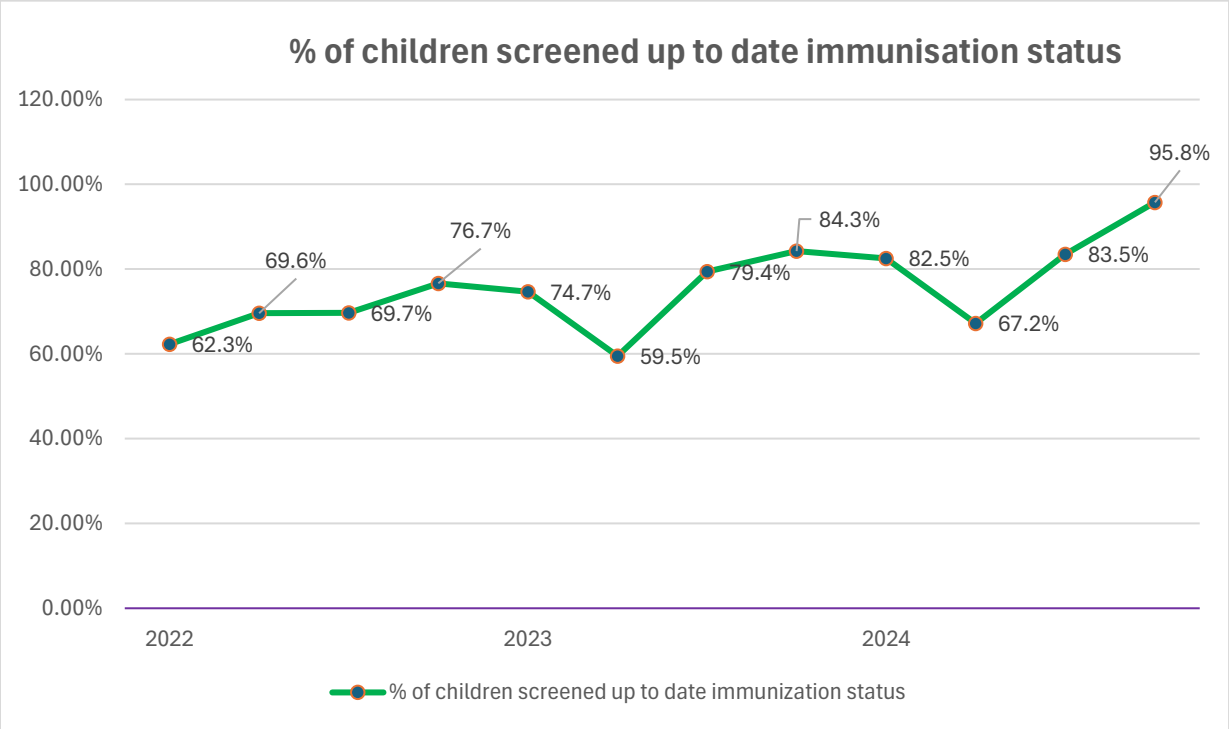
Contrary to an upward trend, the data reveals significant fluctuations. An initial very high peak (128.1% in 2022) is observed, which is likely to suggest either a catch-up effort or a methodological discrepancy, followed by significant troughs, notably at 23.9% in 2023 and 24.8% in 2024.

Despite this instability, the final data point of the period shows a sharp increase, reaching 65.9% by the end of 2024. This strong final performance suggests an increased capacity to integrate vaccination checks into iCCM activities and signals a renewed focus on preventive health services to complement curative care.

11.20 Immunisation (% of patients screened up to date)

This measures the proportion of screened patients whose immunisation is up-to-date. The numerator is the number of screened patients with up-to-date immunisation, and the denominator is the total number of screened patients.

Figure 20 Percentage (%) of children with up-to-date immunisation status among those screened during iCCM activities in OCB, 2022-2024



During the evaluation period, the curve shows a significant overall improvement in the vaccination status of the children who were screened, rising from 62.3% in 2022 to 95.8% by the end of 2024. This suggests significant improvements in follow-up and verification of vaccination status during consultations. However, rather than showing moderate fluctuations, the graph reveals marked volatility in the indicator, with two significant drops: a sharp decline from 74.7% to 59.5% at the end of 2023 and another from 82.5% to 67.2% in mid-2024. These substantial variations could be attributed to the aforementioned

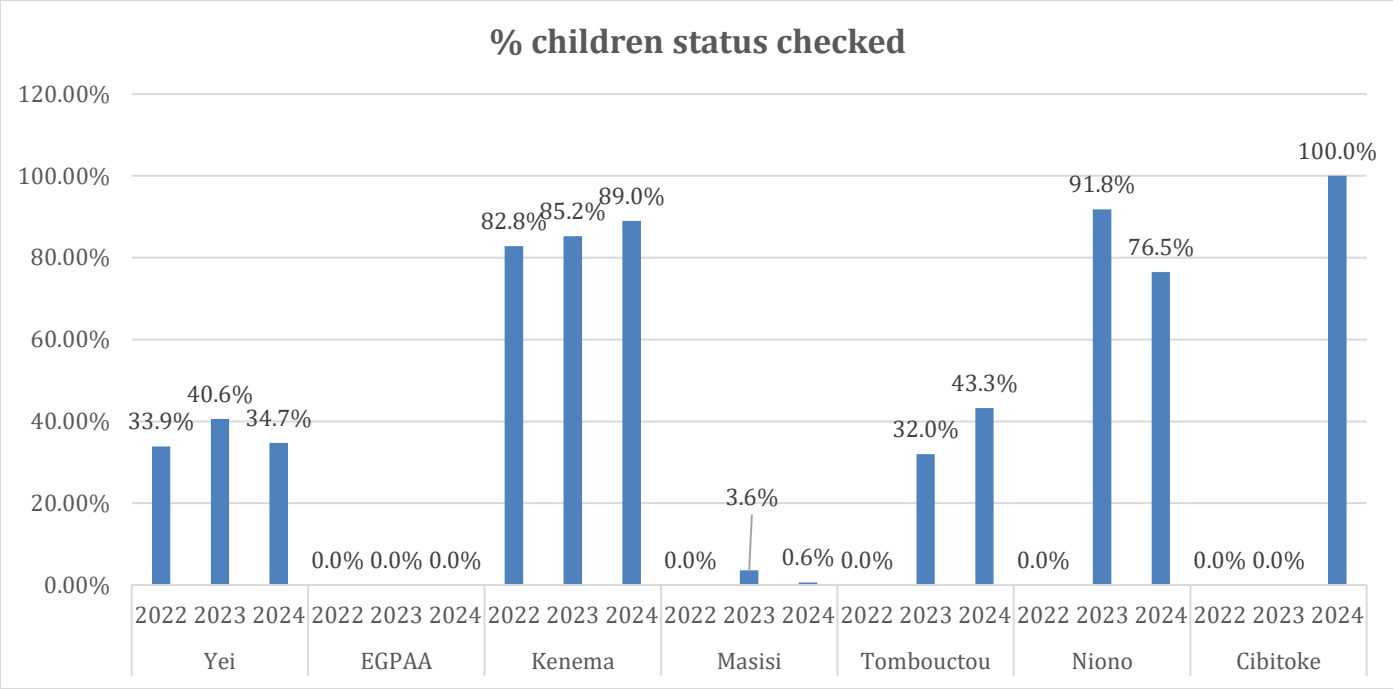
factors (variations in outreach activities, vaccine availability, and the effects of seasonal campaigns), but an in-depth analysis is required to determine the specific causes of these setbacks.
The comment regarding missing data in EGPAA, Masisi, and Kebbi remains relevant, as these reporting gaps must be addressed to ensure comprehensive monitoring.

Immunisation analysis by project site

This indicator captures two dimensions: the percentage of children whose vaccination status was assessed during consultations, and the percentage of those screened who were up to date with their immunisations.

11. 21 Immunisation screening coverage

Figure 21 Percentage (%) of children screened for immunisation status during iCCM activities by project, 2022-2024



Analysing immunization screening data for children across project sites from 2022 to 2024 reveals both successes and persistent gaps in integrating immunization into community-level consultations.

The data reveals strong performance in several locations. For instance, Cibitoke achieved an impressive coverage rate of 100% in 2024, while Kenema reached 89.0%. Niono also performed well, achieving 91.81% coverage in 2023, though this fell to 76.5% in 2024.

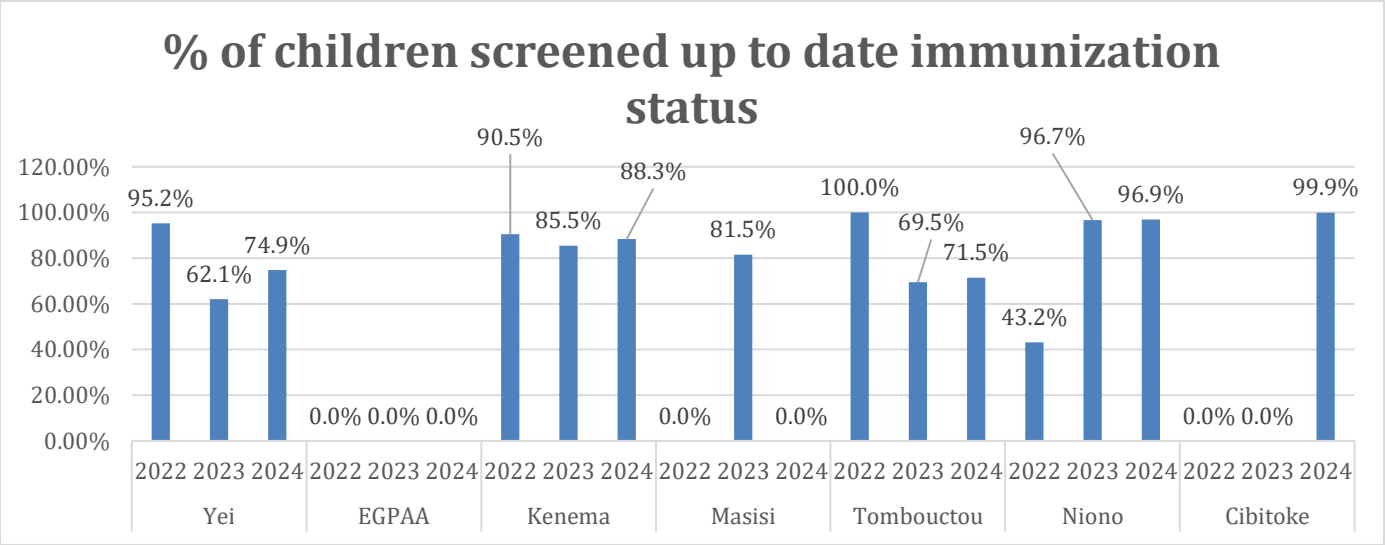
Conversely, significant gaps remain in other sites. The three-year analysis shows that some sites had no screening data at all from 2022 to 2024, like EGPAA, where this represents a complete absence of

immunisation screening activity. Masisi also demonstrated very low coverage, with a marked decline from 3.6% in 2023 to 0.6% in 2024.

Other sites showed variable trends. In Yei, coverage decreased slightly, falling from 40.6% in 2023 to 34.7% in 2024. Tombouctou saw an increase from 32% in 2023 to 43.3% in 2024.

These significant variations in immunisation screening coverage across sites can be attributed to differences in project implementation and specific local contexts.

Figure 22 Percentage (%) of children with up-to-date immunisation status among those screened during iCCM activities by project, 2022-2024



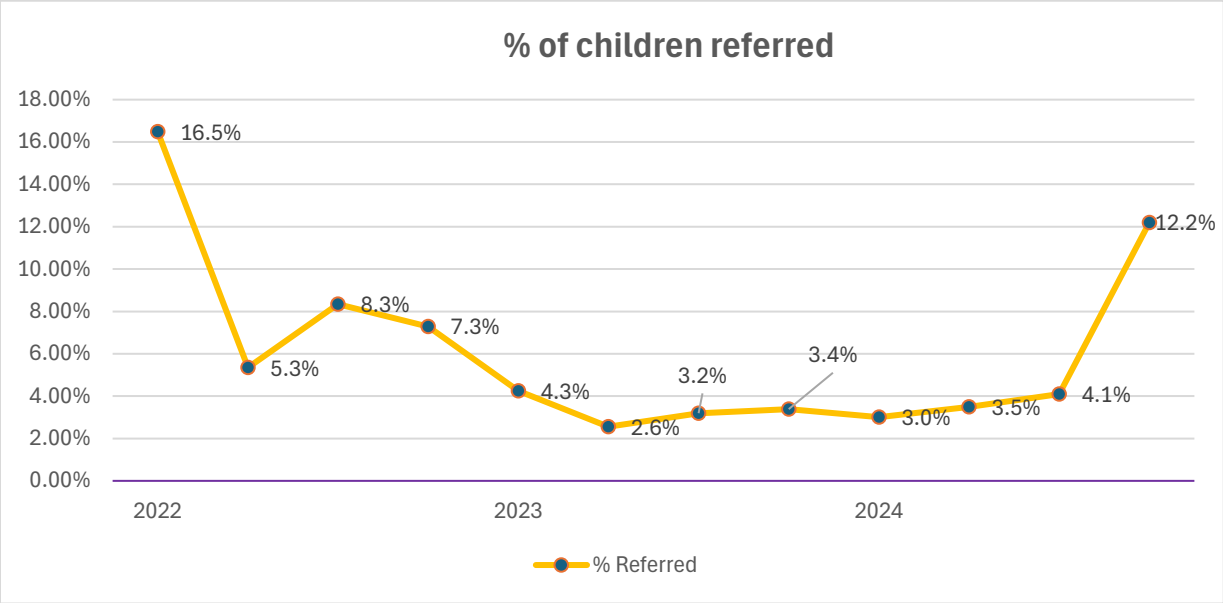
The graph above illustrates the annual fluctuations in the proportion of patients screened with an up-to-date vaccination status across eight iCCM project sites from 2022 to 2024. Overall, progress has been highly volatile, with significant successes and dramatic setbacks in 2024.

While Cibitoke achieved an impressive performance of almost 100% in its single year of intervention (2024), Kenema maintained consistently high performance over three years, and Yei began to recover. Masisi experienced a dramatic collapse, falling from nearly 82% in 2023 to 0% in 2024. Timbuktu recorded a continuous decline, falling from 100% to 10%. Niono, however, started with a modest performance of 43% in 2022, peaking at 97% by the end of the observation period.

11.22 Referrals (% Referred and % Received)

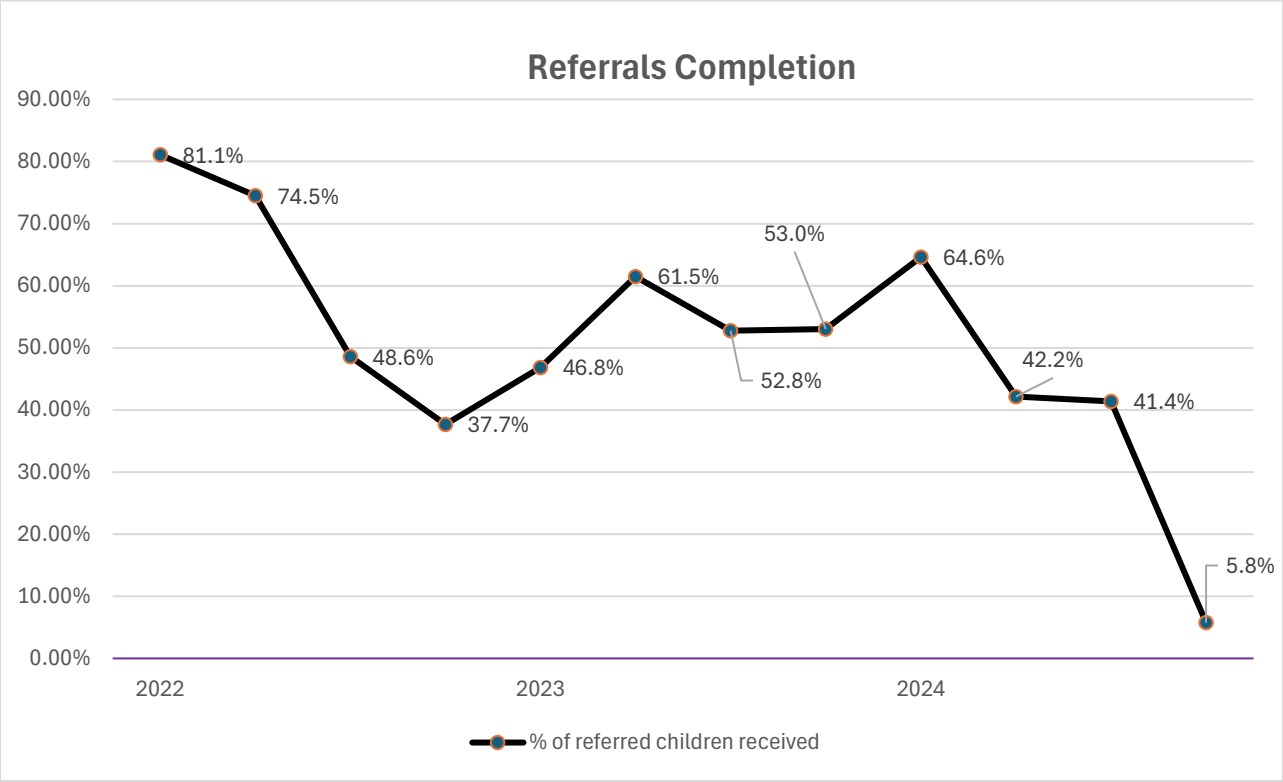
This measures the percentage of new consultations resulting in a referral. The numerator is the number of children referred to the health facility, and the denominator is the total number of new consultations.

Figure 23 Percentage (%) of children referred to health services during iCCM activities in OCB, 2022-2024



The percentage of consultations resulting in a referral to higher-level care showed strong volatility over the period, without following a steady increase. The year 2022 began with a very high rate of 16.5%, followed by a dramatic drop to 5.3% before temporarily stabilizing around 8.3% and 7.3%. In 2023, the rate continued to decline, reaching a low point of 2.6%, and then generally remained between 3% and 4% in early 2024. This period of low referral could indicate strict adherence to managing cases locally. However, a marked and sudden increase is observed at the end of 2024, where the rate spikes to a peak of 12.2%. This erratic trend suggests that CHWs faced significant variations in the burden of morbidity requiring referral, or that the rigor of protocol application fluctuated over the months.

Figure 24 Percentage (%) of children receiving care at a health facility, after being referred during iCCM activities in OCB, 2022-2024



The referral completion rate, defined as the proportion of referred children who arrived at a health facility and received care, exhibited an extremely volatile trajectory and a significant overall decline during this period.

In 2022, the rate started at a high level of 81.1%. However, this rate — indicating that the majority of referred cases— experienced a marked decline in successfully obtaining care at the facility level throughout the year, dropping significantly to reach a low point of 37.7% by the end of the period. This decline raises concerns about potential barriers to accessing care, such as transportation difficulties or ineffective follow-up systems.

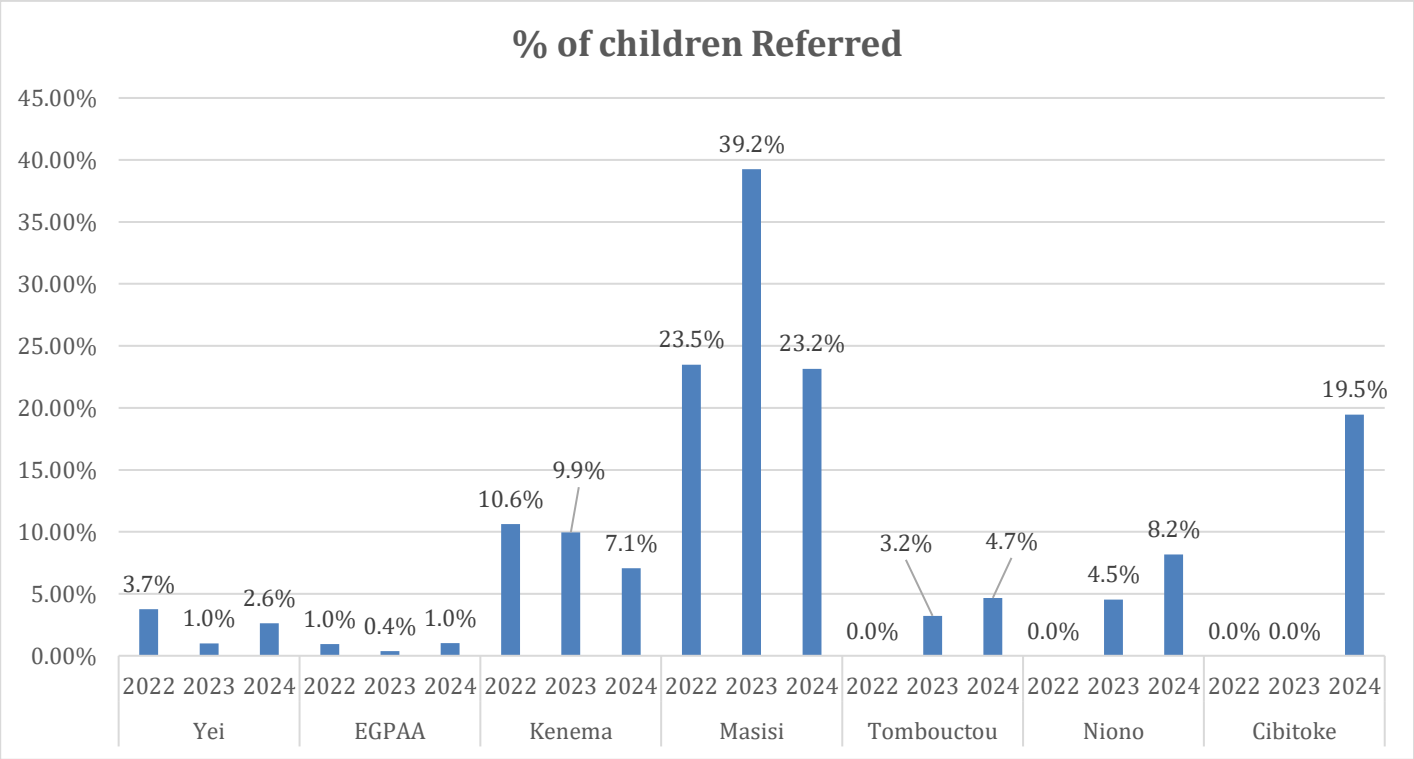
The year 2023 saw a slight recovery and stabilisation. The rate rebounded to reach a mid-year peak of 61.5%, before stabilising at around 53% by the end of 2023. This represented a significant improvement compared to the low point at the end of 2022, suggesting that support measures for caregivers had been implemented.

The beginning of 2024 saw the most encouraging part of the recovery period, with the rate peaking at 64.6%. Unfortunately, this improvement was very short-lived. The rate fell drastically to around 42% by the middle of the year and then collapsed catastrophically to reach an alarming low of just 5.8% by the end of the year.

While recovery efforts in 2023 and early 2024 suggest an attempt to strengthen referral linkages, the persistent volatility and collapse to 5.8% at the end of 2024 highlight the urgent need for sustained action to eliminate barriers to successfully transitioning referred patients to facility-based care.

11.23 Referral analysis by project site

Figure 25 Percentage (%) of children referred to health services during iCCM activities by project, 2022-2024



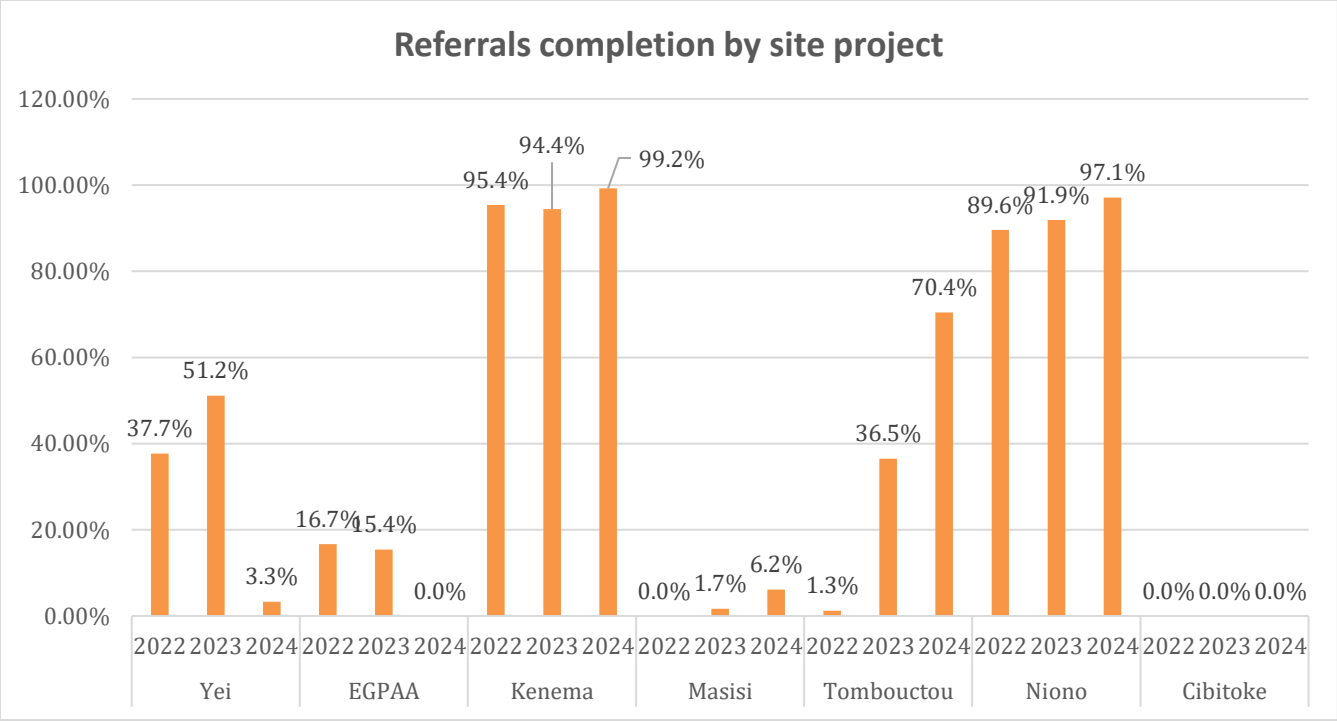
The referral rate, which represents the percentage of children identified by CHWs for referral to higher-level care, varied significantly across sites. Masisi reported the highest and most stable referral rate, ranging from 23.5% to 39.2% of total consultations. This suggests that CHWs have a strong ability to identify danger signs and act according to protocol. Cibitoke also performed well, with referral rates above 15% in the year of the intervention (2024). However, Kenema's referral rate dropped from almost 11% in 2022 to 7% in 2024.

Conversely, EGPAA and Yei recorded some of the lowest referral rates, often below 2%, which could indicate under-detection of severe cases or limited willingness or capacity to refer.

These figures may reflect the technical capacity and operational confidence of the CHWs, with the top-performing sites demonstrating a more proactive approach to identifying severe illness.

11.24 % of Referred Children Received at Facility

Figure 26 Percentage (%) of children receiving care at a health facility, after being referred during iCCM activities by project, 2022-2024



Referral completion, defined as the percentage of referred children received at health facilities, provides essential insight into system connectivity and caregiver follow-through.

Kenema once again led the way in terms of performance, with over 85% of referred children reported as having been received by the facilities.

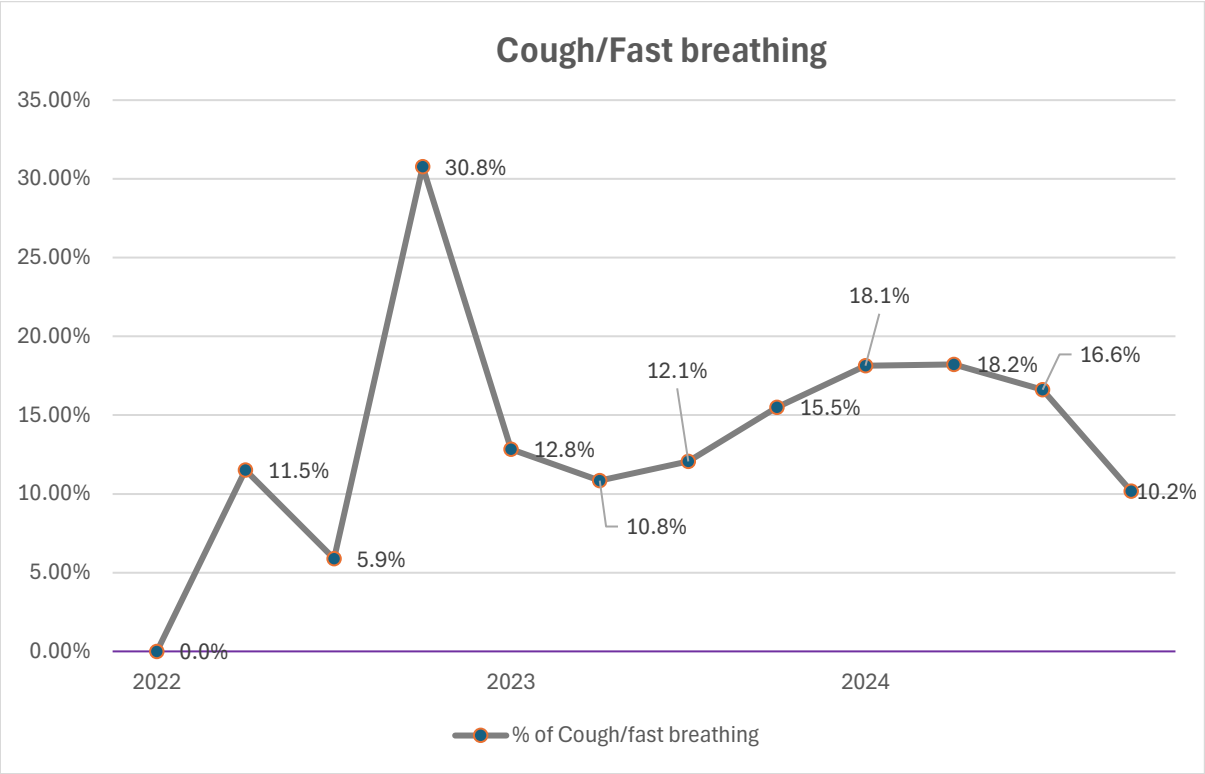
In stark contrast, the Masisi and EGPAA sites showed much poorer performance, with completion rates dropping to 0% in 2024 and under 3% in 2023. These figures likely reflect physical access barriers, high transport costs or reluctance among caregivers.

The data indicates that Kenema and Niono have strong referral systems in place for identification and follow-up. Meanwhile, the Masisi, Cibitoke and EGPAA sites have more fragile referral systems and would benefit from improving continuity of care through community education, increased logistical support, and better feedback mechanisms.

11.25 Cough/fast breathing

This indicator measures the proportion of new consultations for children with symptoms of cough or fast breathing (a proxy for pneumonia cases). The numerator is the number of such cases, and the denominator is the total number of new consultations.

Figure 27 Percentage (%) of children identified with cough or fast breathing symptoms during iCCM activities in OCB, 2022-2024



Upon analysing the data, it was found that the proportion of cough/fast breathing cases among CHW consultations showed high volatility over the study period rather than a sustained reduction.

2022 saw extreme volatility and a major peak. Starting at 0.00%, it rose to 11.5% before dropping to 5.9%. Contrary to the expectation of a consistently high proportion (16–25%), the final quarter saw an exceptional peak of 30.8%, the highest level recorded during the entire evaluation period. This peak suggests a major one-off or seasonal event.

The year 2023 showed moderate stability, contrary to expectations. Following this maximum, the prevalence dropped but stabilised at around 11–13% (12.8%, 10.8% and 12.1%).

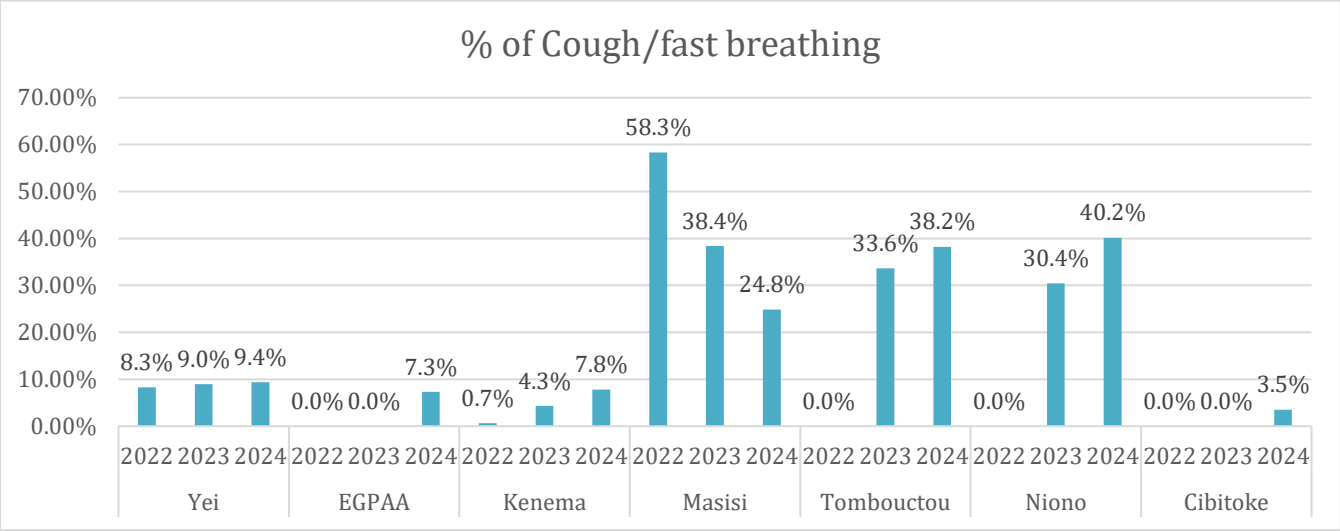
The 2024 data do not confirm maintenance at a low level (6–9%). In fact, the year saw a consistent increase, with rates reaching 18.1% and 16.6% by the middle of the year, before dropping back to 10.2% by the final recorded point.

Conclusion: the observed evolution suggests not a sustained reduction in the incidence of respiratory infections managed by the intervention, but rather a cyclical or fluctuating dynamic, with a resurgence in 2024.

11.26 Cough/fast breathing analysis by project site

The indicator representing the proportion of children with symptoms of cough or fast breathing, a proxy for respiratory infections such as pneumonia, showed considerable variation across sites.

Figure 28 Percentage (%) of children identified with cough or fast breathing symptoms during iCCM activities by project, 2022-2024



Masisi, Niono, and Tombouctou consistently reported the highest proportions, with 24% to 58% of children presenting with respiratory symptoms throughout 2022–2024. This suggests both a high burden of respiratory illness and strong CHW capacity to identify symptoms. EGPAA and Yei also recorded stable rates between 7% and 9%, reflecting effective detection, while Cibitoke recorded a much lower prevalence (3,5%).

While high ARI case detection rates like those in Masisi (DRC), and Tombouctou and Niono (Mali) are encouraging. Persistently low figures in EGPAA and Cibitoké highlight the need for refresher training, job aids, and supervision focused on respiratory illness assessment.

In conclusion, the ARI indicator demonstrates that some sites are capturing respiratory symptoms effectively, while others may be missing opportunities to diagnose and treat pneumonia early. Project quality efforts should prioritise clinical mentoring and protocol reinforcement in underperforming areas.

Conclusion

The iCCM quantitative analysis (2022–2024) reveals substantial advancements in broadening access to community-based healthcare, particularly with regard to new consultations, malaria testing and treatment, and immunisation status checks. The data show a significant increase in service use, with the number of new consultations rising from fewer than 500 in early 2022 to over 58,000 by the end of 2024. This increase was largely driven by high-performing sites such as Yei and EGPAA in South Sudan and Cibitoke in Burundi.

Nutritional screening achieved moderate integration, though with fluctuations and inconsistencies. SAM remained low across most sites (below 4%), while moderate malnutrition persisted at higher rates, especially in Masisi (12–31%) and Tombouctou (approximately 7%), highlighting ongoing vulnerabilities.

Malaria indicators confirm malaria as a dominant health burden, with positivity rates consistently above 60–70%. After initial anomalies, testing coverage stabilised above 70%, and treatment coverage reached near-optimal levels in 2023–2024, before declining suddenly in late 2024, suggesting supply chain fragility.

Diarrhoea and respiratory infections showed marked variability across sites: Masisi and EGPAA had a high prevalence of diarrhoea (>25%), while respiratory cases were particularly prevalent in Mali and DRC sites (24–58%). This highlights gaps in WASH conditions and respiratory case management.

Referral systems remain a critical weakness. Although severe cases were well identified in sites such as Masisi and Kenema, referral completion collapsed to below 6% in several projects by late 2024, reflecting systemic barriers to continuity of care.

In conclusion, although iCCM has successfully increased access to and coverage of services, there are still major challenges in terms of data quality, nutrition screening, the stability of referral systems, and the effectiveness of malaria treatment supply chains. Closing these gaps is crucial to sustaining the significant progress made and ensuring equity across all project sites.